ADRIAN YI, M.D., INC.
16311 VENTURA BLVD., SUITE 550
ENCINO, CALIFORNIA 91436-2131
T: (818) 986-7900 F: (818) 986-7952
www.adrianyimd.com

DATE:_____

PATIENT INFORMATION:

NAME:_____
First Middle Last

ADDRESS: _____
Number Street

_____ _____
City State Zip

HOME PHONE _____ WORK PHONE _____ OTHER PHONE _____

EMPLOYER: _____ OCCUPATION: _____

WORK ADDRESS: _____
Number Street City State Zip

BIRTHDATE: _____/_____/_____ SEX: M F __Single __Married __Divorced __Other EMAIL _____

SOCIAL SECURITY NUMBER: _____ DRIVER'S LICENSE NUMBER: _____

SPOUSE/SIGNIFICANT OTHER/RESPONSIBLE PARTY INFORMATION:

RELATIONSHIP TO PATIENT: ___SELF ___SPOUSE___PARENT ___OTHER

NAME:_____ BIRTHDATE:_____/_____/_____ SEX: M F

ADDRESS: _____
Number Street City State Zip

HOME PHONE _____ WORK PHONE _____ OTHER PHONE _____

WORK ADDRESS: _____
Number Street City State Zip

SOCIAL SECURITY NUMBER: _____ DRIVER'S LICENSE NUMBER: _____

INSURANCE INFORMATION :

PRIMARY INSURANCE: _____ SUBSCRIBER'S NAME: _____

CERTIFICATE/POLICY NUMBER: _____ GROUP NUMBER: _____

SECONDARY INSURANCE: _____ SUBSCRIBER'S NAME: _____

CERTIFICATE/POLICY NUMBER: _____ GROUP NUMBER: _____

NAME OF FAMILY DOCTOR _____
First Name Last Name Phone # Address City Zip

IN CASE OF EMERGENCY, NOTIFY: _____

RELATIONSHIP: _____ HOME PHONE _____ WORK PHONE _____

NEAREST RELATIVE NOT LIVING WITH YOU: _____ PHONE _____

REFERRED BY: _____ MAY WE THANK THEM? ____ YES ____ NO

I authorize you to give me reasonable and proper medical care. I consent to disclose my medical information to be used for treatment, payment and healthcare operations. I understand that this information will be kept in confidence and will not be shared without my permission.

I also authorize _____, my insurance company to pay benefits directly to_____. I authorize Dr. Yi to initiate a complaint to the Insurance Commisioner for any reason on my behalf.

SIGNATURE: _____ DATE: _____

-PLEASE SEE REVERSE-

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We are committed to providing you with the best possible care. If you have medical insurance, we want to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance, and understanding of our payment policy.

Payments for services are due at the time services are rendered unless payment arrangements have been approved in advance by our staff. We accept a variety of payment methods such as, American Express, Discover, MasterCard, Visa, Cash and Checks (when pre-approved). We will be happy to help you process your insurance claim-form for your reimbursement.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance.

You must realize, however, that:

1. Your insurance is a contract between you, your employer and the insurance company.
2. Our fees are generally considered to fall within the acceptable range by most companies, and therefore are usually covered up to the maximum allowance determined by each carrier. This applies only to companies who pay a percentage (such as 70% or 80%) of the "Usual and Customary". This statement does not apply to companies, who reimburse based on an arbitrary schedule of fees, which bears no relationship to the current standard and cost of care in this area.
3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

We must emphasize that as medical care providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility for the date the services are rendered. We realize that temporary financial problems may arise, if so, we encourage you to contact us promptly for assistance in the management of your account.

If you have any questions about the above information or any uncertainty regarding insurance coverage, please do not hesitate to ask us. We are here to assist you.

I have read and understand the above.

SIGNATURE _____ DATE _____

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MEDICAL HISTORY QUESTIONNARIE

We welcome the opportunity to participate in your medical care. To ensure maximum safety and efficiency, we ask that you provide accurate answers to the questions asked relating to your general state of health. All the information will be held confidential as part of your medical records. **PLEASE ANSWER EVERY QUESTION. DO NOT LEAVE A QUESTION BLANK.**

NAME:_____DATE:_____

Age_____ Sex: ☐Male ☐Female Height_____ Weight_____

1. Please list **ALL** medications (including Vitamins, over the counter medications, occasional prescriptions and any homeopathic or herbal medications) you are currently taking or have taken within the last month. Include the following: **Medication, Dosage, and Reason for Medication.**

1._____ 6._____
2._____ 7._____
3._____ 8._____
4._____ 9._____
5._____ 10._____

2. Are you allergic to any medications, foods, medical tapes, latex, etc.? Yes ☐ No If yes, please list, including reaction experienced:
_____

3. Do you have hay fever or seasonal allergies? Yes No If yes, please explain, include method of treatment.
_____

4. Please list all medical, dental and cosmetic surgeries or procedures since birth, which included local or general anesthesia.

Surgery Surgeon (if known) Date (if known)

1._____

2._____

3._____

4._____

5. Have you ever had an anesthetic? Yes No
If, yes, have you ever had problems with anesthesia? Yes No Please explain_____

_____

6. Has anyone genetically related to you ever had any problems with anesthesia? Yes No Please explain_____

_____

7. Do you or have you smoked (includes all nicotine use)? Yes No If yes, please describe type, amount and duration of nicotine habit_____

8. Do you drink alcoholic beverages? Yes No If yes,please explain_____

9. Have you ever or are you currently addicted or habituated to any form of medicine, drugs, or alcohol? Yes No
If yes, please explain _____

FAMILY HISTORY Include all members of your genetic family, living or deceased. Please specify your relationship to the family member.

Cancer_____Type_____ Diabetes_____ Hay Fever_____

Tuberculosis_____ High Blood Pressure_____ Heart Disease_____

Stroke _____ Asthma _____

QUESTIONNAIRE CONTINUES ON NEXT PAGE

HEART AND LUNGS

YES NO Have you ever had an abnormal chest x-ray or EKG? If yes, please list when and findings_____

YES NO Have you ever been hospitalized with pneumonia? If yes, please explain_____

YES NO Do you have chronic cough or night sweats? If yes, please explain_____

YES NO Have you ever had a positive TB (Tuberculosis) test? If yes, please explain_____

YES NO Do you have or ever had asthma, even as a child? If yes, please explain when it was diagnosed, method of treatment, and last attack_____

YES NO Do you presently have or have you had within the last two weeks, a cough? If yes, please explain

YES NO Have you ever been diagnosed with a heart murmur, MVP (Mitral Valve Prolapse), irregular heart beat, or do you have an artificial heart valve? If yes, please explain_____

YES NO Have you ever had a heart attack or heart surgery? If yes, please explain_____

YES NO Have you ever sought medical attention for chest pain or shortness of breath? If yes, please explain treatment_____

YES NO Do you have or have you ever been diagnosed with high blood pressure? If yes, please explain_____

ABDOMINAL CAVITY/ORGANS

YES NO Have you ever had any type of kidney disease or been on dialysis? If yes, please explain_____

YES NO Have you ever been diagnosed with jaundice? If yes, please explain_____

YES NO Have you ever had hepatitis? If yes, please explain_____

YES NO Have you ever had any type of liver disease? If yes, please explain_____

YES NO Do you suffer from heartburn, or have you ever been diagnosed with stomach ulcers?_____

YES NO Have you ever been diagnosed with diabetes? If yes, please explain_____

HEAD AND NECK

YES NO Do you suffer from frequent headaches? If yes, please explain_____

YES NO Have you ever experienced a period of unconsciousness or had a fainting episode? If yes, please explain_____

YES NO Have you ever had a seizure? If yes, please explain_____

YES NO Have you ever had a stroke? If yes, please explain_____

YES NO Have you ever been diagnosed with Alzheimer or dementia? If, yes please explain_____

YES NO Have you ever been diagnosed with thyroid disease? If yes, please explain_____

GENERAL HISTORY

YES NO Have you ever been diagnosed with HIV or AIDS? (**Please remember that this will be held confidential as part of your medical history)** If yes, please explain_____

YES NO Have you ever been diagnosed with any type of cancer? If yes, please explain_____

YES NO Do you have any back problems? If yes, please explain_____

YES NO Do you have arthritis? If yes, please explain_____

YES NO Do you have any physical disabilities? If yes, please explain_____

YES NO Do you have any bleeding tendencies, blood clots or been diagnosed with hemophilia? If yes, please explain_____

YES NO Do you take any medications to thin the blood (i.e. Heparin, Coumadin) If yes, please list_____

YES NO Have you used any aspirin or Vitamin E products in the past two week? If yes, please list_____

YES NO Do you have dentures, caps, loose teeth, bridgework or braces? If yes, please list_____

YES NO Have you ever had any unexplained weight loss or weight gain? If yes, please explain_____

Is there anything else you feel you should tell us?_____

FEMALES ONLY

Are you or could you be pregnant? YES NO Method of birth control:_____

Date of last menstrual period:_____ # of all prior pregnancies_____ #of live births_____

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PATIENT CONSENT FOR MEDICAL PHOTOGRAPHY

PATIENT NAME:_____ **DATE:**_____

Medical photography is essential for legal documentation of your pre-operative condition and for planning of cosmetic surgery as well as medical education. I consent to photography of appropriate portions of my face or body in preparation for surgery and for post-operative follow-up to be made of me or my child (or person for whom I am legal guardian of). The undersigned grants Dr. Adrian Yi the on-going and un-restricted right to use the undersigned's image for general information, education, scientific, medical and public relations purposes.

Authorization and/or consent as outlined above is hereby granted. I hold the physician, it's agents and employees harmless from any claim for injury or compensation resulting from activities authorized by this agreement.

Authorization and/or consent as outlined above is hereby granted.

Patient Signature:_____ Date:_____

Witness Signature:_____ Date:_____

CONSENT BY PARENT OR GUARDIAN:

I am the parent or legal guardian of_____, minor. I am authorized to sign this consent on his/her behalf, and agree on my own behalf and his/her behalf to the terms of the foregoing consent.

Parent or Legal Guardian Signature:_____ Date:_____

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PROTECTED HEALTH INFORMATION DISCLOSURE RECORD

PATIENT NAME:_____ **D.O.B.:**_____

Please list any person that you authorize to discuss any appointments for financial matters with us. If any person should call requesting to make an appointment for you or to discuss any financial matters regarding your account, we will not assist them unless their name and relationship is listed on this form. This policy is in order to protect your personal health information.

Person(s) authorized to discuss my appointments, account, etc.:

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Please tell us the authorized methods of communications you prefer.
Check all the apply:

☐ Residence telephone Number:_____
Is it ok to leave a message with a call back number? Yes or No
Is it ok to leave a detailed message with a person? Yes or No
Is it ok to leave a message on an answering machine? Yes or No

☐ Work telephone Number:_____
Is it ok to leave a message with a call back number? Yes or No
Is it ok to leave a detailed message with a person? Yes or No
Is it ok to leave a message on an answering machine? Yes or No

☐ Cell phone Number:_____
Is it ok to leave a message with a call back number? Yes or No

Please tell us how you would like us to send written correspondence:

☐ Home address Address: _____

☐ Work address Address: _____

☐ Other Address: _____

Patient signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICES

Adrian Yi, M.D., Inc.
Notice of Privacy Practices
This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.
If you have any questions about this Notice please contact:
Our Privacy Contact who is Stefanie A. Barrios

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required by applicable federal and state laws to maintain the privacy of your personal and health information. Both under law and by our policy, Adrian Yi, MD, Inc. has a responsibility to protect the privacy of your personal and health information (PHI). We will:

- Protect your privacy by limiting you may see your PHI;
- Limit how we may use or disclose your PHI;
- Inform you of our legal duties with respect to your PHI;
- Explain our privacy policies; and strictly adhere to the policies currently in effect.

You have received this notice because you are under the care of Adrian Yi, M.D., Inc. This is a notice of privacy practices, our legal duties, and your rights concerning your personal and health information. We follow the privacy practices that are described in this notice while it is in effect. This notice takes effect February 1, 2003 and will remain in effect until we replace it and provide you notice of such changes. We reserve the right to change our privacy practices and the terms of this notice at any time, as allowed by applicable law, rules and regulations. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all personal and health information that we maintain, including information we created or received before we made the changes. When we make a significant change in our privacy practices, we will make the notice available to our patients, upon request, on or after the effective date of the change. For more information about our privacy practices, or for additional copies of this notice, please contact our office at the number listed at the end of this notice.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information Based Upon Your Written Consent
You will be asked by your physician to sign a consent form. Once you have consented to use and disclosure of your protected health information for treatment, payment and health care operations by signing the consent form, your physician will use or disclose your protected health information as described in this Section 1. Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of the physician's practice.
Following are examples of the types of uses and disclosures of your protected health care information that the physician's office is permitted to make once you have signed our consent form. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office once you have provided consent.
Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your protected health information. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you when we have the necessary permission from you to disclose your protected health information. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.
In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.
Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as; making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing and fundraising activities, and conducting or arranging for other business activities.
For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.
We will share your protected health information with third party "business associates" that perform various activities (e.g., billing, and transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.
We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your protected health information for other marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer. We may also send you information about products or services that we believe may be beneficial to you. You may contact our Privacy Contact to request that these materials not be sent to you.
We may use or disclose your demographic information and the dates that you received treatment from your physician, as necessary, in order to contact you for fundraising activities supported by our office. If you do not want to receive these materials, please contact our Privacy Contact and request that these fundraising materials not be sent to you.

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization
Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Other Permitted and Required Uses and Disclosures That May Be Made With Your Consent, Authorization or Opportunity to Object
We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician may, using professional judgement, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Emergencies: We may use or disclose your protected health information in an emergency treatment situation. If this happens, your physician shall try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If your physician or another physician in the practice is required by law to treat you and the physician has attempted to obtain your consent but is unable to obtain your consent, he or she may still use or disclose your protected health information to treat you.

Communication Barriers: We may use and disclose your protected health information if your physician or another physician in the practice attempts to obtain consent from you but is unable to do so due to substantial communication barriers and the physician determines, using professional judgement, that you intend to consent to use or disclosure under the circumstances.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Consent, Authorization or Opportunity to Object
We may use or disclose your protected health information in the following situations without your consent or authorization. These situations include:
Required By Law: We may use or disclose your protected health information to the extent that law requires the use or disclosure. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.
Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your protected health information, if

directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of the practice, and (6) medical emergency (not on the Practice's premises) and it is likely that a crime has occurred.

Coroners, Funeral Directors, and Organ Donation: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

Research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities including for the provision of protective services to the President or others legally authorized.

Workers' Compensation: We may disclose your protected health information as authorized to comply with workers' compensation laws and other similar legally established programs.

Inmates: We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 et. seq.

2. Your Rights

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. A "designated record set" contains medical and billing records and any other records that your physician and the practice uses for making decisions about you.

Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be revisable. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Contact if you have questions about access to your medical record.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.
Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If your physician does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician. You may request a restriction by submitting a letter in writing to our office.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Contact.
You may have the right to have your physician amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Contact to determine if you have questions about amending your medical record.
You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you, for a facility directory, to family members or friends involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. You may request a shorter timeframe. The right to receive this information is subject to certain exceptions, restrictions and limitations.
You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

3. Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe we have violated your privacy rights. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

You may contact our Privacy Contact, **Stefanie A. Barrios** at (818) 986-7900 or email stefanieb@adrianyimd.com

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PRIVACY PRACTICES ACKNOWLEDGEMENT

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

NAME OF PATIENT (PRINT):_____

SIGNATURE OF PATIENT OR GUARDIAN:_____

DATE:_____