Sienna Podiatry
Dr. Holly Spohn-Gross, DPM

6425 Lynch Canyon Drive
Lake Isabella, CA 93240
(Phone) 760-379-8630

1661 Triangle Drive Suite A.
Ridgecrest, CA 93555
(Fax) 760 379-7658

PATIENT INFORMATION

First Name: _____Middle: _____Last: _____

Date of Birth: _____Age: _____ Sex:_____SSN:_____

Mother's Maiden Name: _____

CONTACT INFORMATION

Cell Phone: _____Home Phone: _____

Work Phone: _____Email Address: _____
(for electronic access to medical records)

Preferred method of communication: (Please choose only one)
□ Email □ Mail □ Home phone □ Mobile phone □ Work phone

ADDRESS/MAILING INFORMATION

Mailing Address: _____

City: _____State: _____Zip Code: _____

Physical Address: _____

City: _____State: _____Zip Code: _____

PHYSICIAN & PHARMACY INFORMATION

Primary Care Physician:_____

Preferred Pharmacy: Name_____

Address_____

DEMOGRAPHIC INFORMATION

Race: □ American Indian or Alaska Native □ Native Hawaiian or other Pacific Islander □ Black or African American
□ White □ Asian □ Other_____
□ Decline to Specify

Ethnicity: □ non-Hispanic □Hispanic □Decline to Specify Preferred language: _____

Gender Identity: _____ Sexual Orientation: _____

EMERGENCY CONTACT/NEXT OF KIN

First & Last Name: _____ Phone Number: _____

Address: _____

GRANT ACCESS TO YOUR MEDICAL INFORMATION

We may discuss Your health information with the following people (Caregivers, Family Members, etc.)

Name:_____ Relationship:_____Phone: _____
Name:_____ Relationship:_____Phone: _____

SIGNATURE

By signing below, I agree that all information provided is accurate and up to date to the best of my knowledge. By signing I consent to allow prescription history to be gathered electronically through my preferred pharmacy and to receive appointment reminders and messaging via email, voice, and text messaging. By signing I consent to have digital photos of my likeness and/or medically necessary digital photos uploaded to my electronic medical record. By signing I consent to allow immunization registry to be documented online.

_____/_____

Patient/Guardian Signature Date

We will need a copy of your insurance card and form of picture ID.
All payments, co-payments, and deductibles will be due at time of visit.

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COMPREHENSIVE HEALTH REVIEW

Patient Name:_____ Date of Birth:_____ Today's Date:_____

HISTORY OF PRESENT ILLNESS / WHAT BRINGS YOU IN?

What is your specific foot/ankle problem? _____

_____

_____

When did the problem begin? _____

The problem is: ☐ Improving ☐ Worsening ☐ Unchanged

What aggravates the problem? _____

Which foot/ankle is involved? ☐ Right ☐ Left ☐ Both

First visit to a doctor for this problem? ☐ Yes ☐ No

Have you had a similar problem in the past? ☐ Yes ☐ No

How was the problem onset? ☐ Sudden ☐ Gradual

The problem is worst: ☐ AM ☐ PM ☐ At Rest ☐ With Activity

What improves the problem? _____

Is the problem painful? ☐ Yes ☐ No If so, rate your current pain: (none) 0 1 2 3 4 5 6 7 8 9 10 (worst)

Describe the pain: ☐ Sharp ☐ Dull ☐ Aching ☐ Throbbing ☐ Cramping ☐ Itching ☐ Popping

☐ Burning ☐ Tingling ☐ Clicking ☐ Shooting ☐ Stabbing ☐ Other: _____

Describe Previous Treatments: _____

Is this from an injury? ☐ Yes ☐ No If so, is it work related? ☐ Yes ☐ No _____

PAST MEDICAL HISTORY

☐ Diabetes Type 1 2 Duration_____ Last Blood Sugar_____ HbA1c years_____

☐ Acid Reflux

☐ Anemia

☐ Anesthesia Complications

☐ Arthritis (☐ Osteo / ☐ Rheum)

☐ Asthma

☐ Back Problems/Sciatica

☐ Blood Clot/DVT

☐ Cancer: _____

☐ Cellulitis/Skin Infection(☐ MRSA?)

☐ Circulation Problem

☐ Dementia/Alzheimer's

☐ Excessive/Easy Bleeding

☐ Fibromyalgia

☐ Foot/Leg Ulcer

☐ Gout

☐ Healing Problems/Keloids

☐ Heart Disease/Heart Attack

☐ High Blood Pressure (☐ Low BP?)

☐ High Cholesterol

☐ Hormone Therapy

☐ Immune Disorder/HIV

☐ Kidney Disease (☐ Dialysis)

☐ Liver Disease (☐ Hepatitis)

☐ Leg Cramps/Leg Pain at Rest

☐ Lung Condition: _____

☐ Mitral Valve Prolapse/Murmur

☐ Multiple Sclerosis

☐ Nervous Disorder/Depression

☐ Neuropathy

☐ Osteomyelitis/Bone Infection

☐ Parkinson's Disease

☐ Previous Addiction to: _____

☐ Pulmonary Embolism

☐ Rashes/Skin Condition

☐ Raynauds Disease/Phenomena

☐ Seizure Disorder/Epilepsy

☐ Sickle Cell Disease/Trait

☐ Sleep Apnea

☐ Stomach Ulcers

☐ Stroke ☐ Rt ☐ Lt (year_____)

☐ Thyroid Condition (☐ Hi ☐ Lo)

☐ Varicose Veins

☐ Women – Are Your Pregnant or Breast Feeding?

☐ Other problems not listed: _____

PAST SURGERIES

☐ Foot/Ankle Surgery: _____

☐ Joint Replacement: _____

☐ Open Heart/Bypass Surgery

☐ Hysterectomy ☐Tubal Ligation ☐ C-Section

☐ Stent Placement: Heart Leg

☐ Cosmetic Surgery:_____

☐ Appendix ☐ Gallbladder ☐ Tonsils/Add

☐ Leg Bypass ☐ Open Fracture Repair

☐ Carotid Surgery ☐ Vein Surgery

☐ Hernia Repair ☐ Thyroid ☐ Back Surgery

☐ Other: _____

FAMILY HISTORY (circle relative)

	Mother	Father	Sister	Brother	GrandParent
☐ Cancer	M	F	S	B	GP
☐ Diabetes	M	F	S	B	GP
☐ Gout	M	F	S	B	GP
☐ Heart Disease	M	F	S	B	GP
☐ High Blood Pressure	M	F	S	B	GP
☐ Severe Arthritis	M	F	S	B	GP
☐ Anesthesia Complications	M	F	S	B	GP
☐ Foot Problems	M	F	S	B	GP
☐ Other: _____	M	F	S	B	GP

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COMPREHENSIVE HEALTH REVIEW

Patient Name:_____Date of Birth: _____

MEDICATIONS (include RX meds, OTC meds, and vitamins)

Medication	*Dosage*	*Medication*	*Dosage*
_____		_____	
_____		_____	
_____		_____	
_____		_____	
_____		_____	

ALLERGIES

☐ None
☐ Adhesives/Taps
☐ Aspirin
☐ Codeine
☐ Cortisone
☐ Iodine
☐ Latex
☐ Local Anesthetics
☐ Penicillin
☐ Seafood/Shellfish
☐ Sulfa Drugs
☐_____

SOCIAL HISTORY

Occupation: _____

☐ I Drink Alcoholic Beverages How much/often? _____

☐ I Use or Have Used Tobacco Products Type: _____

Packs/Day _____ Years _____ When Stopped? _____

☐ I Use or Have Used Drugs that are illegal _____

I Stand _____ % of My Day

I Exercise Each Week: ☐ 0 Days ☐ 1-2 Days ☐ 3+ Days

List Sports/Activities: _____

_____

☐ My foot/ankle problem limits my activities

REVIEW OF SYPMTOMS

CONSTITUTIONAL
☐ Recent Weight Changes
☐ Fever/Chills
☐ Nausea or Vomiting
☐ Fatigue

EYES
☐ Eye Disease/Injury
☐ Wear Glasses/Contacts
☐ Blurred or Double Vision
☐ Glaucoma

EARS/NOSE/MOUTH/THROAT
☐ Hearing Loss
☐ Nose Bleeds
☐ Sore Throat/Voice Change
☐ Sinus Problems
☐ Difficulty Swallowing

CARDIOVASCULAR
☐ Chest Pain
☐ Palpitations
☐ Arrhythmia/Irregular Heart Beat
☐ Leg Pain when Walking
☐ Swelling of Hands/Feet

MUSCULOSKELETAL
☐ Muscle Pain or Cramps
☐ Joint Pain
☐ Stiffness/Swelling Joints
☐ Low Back Pain
☐ Trouble Walking

GASTROINTESTINAL
☐ Indigestion/Heartburn
☐ Diarrhea
☐ Blood in Stools
☐ Stomach Pains

RESPIRATORY
☐ Shortness of Breath
☐ Chronic/Frequent Cough
☐ Wheezing

GENITOURINARY
☐ Frequent Urination
☐ Painful Urination
☐ Kidney Stones
☐ Blood in Urine

INTEGUMENTARY
☐ Rash or Itching
☐ Dry Skin
☐ Change in Hair/Nails

HEMATOLOGICAL
☐ Bruise Easily
☐ Slow to Heal

ENDOCRINE
☐ Hormonal Problem
☐ Excessive Thirst
☐ Excessive Urination
☐ Too Hot/Too Cold

NEUROLOGICAL
☐ Migraines
☐ Frequent Headaches
☐ Numbness/Tingling
☐ Dizzy Spells
☐ Paralysis/Tremors

PSYCHIATRIC
☐ Anxiety
☐ Depression
☐ Nervousness
☐ Insomnia
☐ Confusion/Memory Loss

STATS

For Office Staff

Age_____ Height_____ Weight_____ Shoe Size_____ BP_____ P_____ O2 Sat_____ Temp _____ BMI_____

SIGNATURE

The information I have provided is true to the best of my knowledge. I recognize that the information I have provided will help me to receive the best care possible. I understand is my responsibility to inform the facility's staff of any changes in my medical/mental status.

Patient/Guardian Signature_____ Date: _____

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AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

I authorize_____
(Name and address of physician or health care provider authorized to use or disclose information)

To furnish to_____
(Name and address of person/organization to which disclosure is made)

Health information described below on: _____
(*Patient name)*

For the purpose of: _____

This information is limited to the following type and amount of information. (Use dates where appropriate).

- □ Progress Notes
- □ Consultation Reports
- □ Laboratory, Pathology Reports
- □ Radiology Reports/Imaging Reports
- □ Medical Records relating to injury
- □ Other: _____
- □ Immunization Records
- □ Any and all records for the last 2 years

DISCLOSURES REQUIRING SPECIAL CONSENT:
My signature below specifically authorizes the release of healthcare information relating to the testing, diagnosis, or treatment for: (initial appropriate area)

HIV/AIDS virus_____ Mental Health/Psychiatric Disorders_____
Sexually Transmitted Diseases_____ Drug, Alcohol Abuse/Treatment_____

I understand that I have a right to revoke this authorization at any time. I understand that my revocation must be in writing and presented to the Health Information Management Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date event or condition:

_____

If I fail to specify an expiration date, event or condition, this authorization will expire in six months.

Neither treatment, payment, enrollment nor eligibility for benefits will be conditioned on my providing or refusing to provide this authorization. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Director of Health Information Management. I understand I have a right to receive a copy of this authorization.

_____/_____
Signature of Patient, Parent or Legal Guardian — Patient Date of Birth

_____
Patient Address

_____/_____
If signed by other than patient, indicate relationship — Patient telephone number

_____/_____
Witness signature — Date

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OFFICE FINANCIAL POLICY

Patient Name: _____ Date of Birth: _____

Basic Policy: Payment for services is due in full at the time of service. There will be a $30.00 service charge for returned checks.

For Patients with Insurance: **Co-payments and deductibles are due at the time of service.** As a convenience to our patients, we will bill most primary and/or secondary insurance carriers for you. If the insurance carrier(s) deny the claim for any reason, I understand that I am responsible for any and all applicable fees, less any co-payment and/or deductible payments made to date.

Surgery Fees: All co-pays, deductibles and payments for non-covered surgical procedures are due prior to your surgery. Prior authorization may be required by your carrier.

Worker's Compensation: If your injury is work-related, we will need the case number and carrier name prior to your visit in order to bill the worker's compensation insurance company.

Yearly Health Checks: Periodic preventive health checks may or may not be covered under your health insurance policy; however, they may be required by your physician.

Missed Appointments: In fairness to other patients and the physicians, we require at least 24-hour notice to cancel or reschedule appointments. **We will directly charge the patient $50.00 for appointments cancelled with less than 24-hour notice. We will also directly charge the patient $50.00 for every "no show" (missed) appointment.**

PATIENTS SIGNATURE ON FILE: I request payment of authorized medical benefits be made on my behalf to **Sienna Wellness Institute** for any services furnished me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claims. If "other health insurance" is indicated on other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown. In Medicare assigned cases, the provider or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

ASSIGNMENT OF INSURANCE BENEFITS:

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, private insurance, and any other health plans, to **SIENNA WELLNESS INSTITUTE/SIENNA PODIATRY, PC**. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I understand that I am financially responsible for all charges if I provide incorrect insurance information at the time of service. I hereby authorize said assignee to release all information necessary to secure the payment.

I have read, understood, and agree to the above financial policy for payment of professional fees. I understand that the patient is ultimately responsible for all professional fees.

_____/_____
Patient/Guardian Signature Date

_____/_____
Facility Representative Signature Date

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ADVANCE BENEFICIARY NOTICE (ABN)

Patient Name: _____Date of Birth: _____

The purpose of this form is to help you make an informed choice about whether or not you want to receive services and/or items.

In the event your insurance company fails to pay for services rendered or the insurance you supplied is inactive or inaccurate on the date the Provider provides services, the patient is responsible for all payments.

It is your responsibility to know your insurance policy and what it does and does not cover, such as:

1. **DEDUCTIBLE's (In or out of network)**
2. **COPAY's**
3. **NON-COVERED BENEFITS**

Our facility and its Providers participate with many different insurance policies and plans.

It is also your responsibility to know if our facility and its Providers participate with your individual insurance plan.

By signing below, I am aware I may be billed for services and/or items not covered by the insurance company and plan I provided and agree to pay any such charges.

_____/_____

Patient/Guardian Signature Date

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Open Payments Database

Patient Name: _____Date of Birth: _____

The federal Centers for Medicare and Medicaid Services (CMS) requires your signature as proof of receiving the following information:

The Open Payments Database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at https://openpaymentsdata.cms.gov.

For informational purposes only, a link to the federal Centers for Medicare and Medicaid Services (CMS) Open Payments web page is provided here. The federal Physician Payments Sunshine Act requires that detailed information about payment and other payments of value worth over ten dollars ($10) from the manufacturers of drugs, medical devices, and biologics to physicians and teaching hospitals be made available to the public.

Please indicate if you would like a copy of this notice at time of initial appointment.

- ☐ A copy of this notice was given to me at time of service, and a copy was included in my medical records.
- ☐ I do not wish to receive a copy of this notice at time of service. However, it will be placed in my medical records and available to me at any time.

_____/_____
Patient/Guardian Signature Date

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Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name: _____Date of Birth: _____

I certify that I received a copy of Sienna Medical Corporation/Sienna Podiatry Notice of Privacy Practices.

The Notice of Privacy Practices describes the type of uses and disclosures of my protected health information that might occur in my treatment, payment of my bills, or in the performance of Sienna Medical Corporation/Sienna Podiatry's health care operations.

The Notice of Privacy Practices also describes my rights and Sienna Medical Corporation/Sienna Podiatry's duties with respect to my protected health information.

The Notice of Privacy Practices is posted in the lobby and on Sienna Medical Corporation/Sienna Podiatry's website at www.siennawellness.com.

Sienna Medical Corporation/Sienna Podiatry reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may request a revised copy from the facility at any time.

_____/_____

Patient/Guardian Signature Date

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DHCS
California Department of
HealthCareServices

P.O. Box 997413 MS 4721
Sacramento, CA 95899-7413
(866)866-0602 or (877) 735-2929 TTY/TTD
http://dhcs.ca.gov/privacyoffice

Your Information. Your Rights. Our Responsibilities.

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.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of your health and claims records	• You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct health and claims records	• You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this. • We may say “no” to your request, but we’ll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will consider all reasonable requests, and must say “yes” if you tell us you would be in danger if we do not.

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continued on next page

Your Rights *continued*

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say "no" if it would affect your care.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

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Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in payment for your care • Share information in a disaster relief situation • Contact you for fundraising efforts *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we never share your information unless you give us written permission:	• Marketing purposes • Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Help manage the health care treatment you receive	• We can use your health information and share it with professionals who are treating you.	***Example:*** *A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.*
Run our organization	• We can use and disclose your information to run our organization and contact you when necessary. • **We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage.** This does not apply to long term care plans.	***Example:*** *We use health information about you to develop better services for you.*
Pay for your health services	• We can use and disclose your health information as we pay for your health services.	***Example:*** *We share information about you with your dental plan to coordinate payment for your dental work.*

Administer your plan	• We may disclose your health information to your health plan sponsor for plan administration.	***Example:*** *Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.*

continued on next page

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as: • Preventing disease • Helping with product recalls • Reporting adverse reactions to medications • Reporting suspected abuse, neglect, or domestic violence • Preventing or reducing a serious threat to anyone's health or safety
Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests and work with a medical examiner or funeral director	• We can share health information about you with organ procurement organizations. • We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you: • For workers' compensation claims • For law enforcement purposes or with a law enforcement official • With health oversight agencies for activities authorized by law • For special government functions such as military, national security, and presidential protective services
Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.
Conduct outreach, enrollment, care coordination and case	• We can share your information with other government benefits programs like Covered California for reasons such as outreach, enrollment, care coordination, and case management.

management

Appeal a DHCS decision	• We can share your information if you or your provider appeal a DHCS decision about your health care.
Apply for full scope Medi-Cal	• If you are applying for full scope Medi-Cal benefits, we must check your immigration status with the U.S. Citizenship and Immigration Services (USCIS).
Join a managed care plan	• If you are joining a new managed care plan, we can share your information with that plan for reasons such as care coordination and to make sure that you can get services on time.

continued on next page

Administer our programs	• We can share your information with our contractors and agents who help us administer our programs.
Comply with special laws	• There are special laws that protect some types of health information such as mental health services, treatment for substance use disorders, and HIV/AIDS testing and treatment. We will obey these laws when they are stricter than this notice.

We will never market or sell your personal information.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you. Effective Date: September 23, 2013

This Notice of Privacy Practices applies to the following organizations.

- This notice applies to all DHCS programs, including Medi-Cal. For a full list of programs currently run by DHCS, please visit our website at **www.dhcs.ca.gov/services.**

For More Information

Please contact us to request a copy of this notice in other languages or to get a copy in another format, such as large print or Braille.

DHCS does not have full copies of your medical records. If you want to look at, get a copy of, or change your medical records, please contact your doctor, dentist, or health plan first.

DHCS Privacy Officer

P.O. Box 997413 MS 4721
Sacramento, CA 95899-7413 Phone: **(866) 866-0602** Option 1, or (877) 735-2929 TTY/TTD

Fax: (916) 327-4556

Email: privacyofficer@dhcs.ca.gov