PEDIATRIC PATIENT DEMOGRAPHIC FORM

Andrew L. Nash M.D., 911 San Ramon Valley Blvd. Suite 100, Danville CA 94596 (925) 362-1861

PATIENT

Date:	Patient#:	Patient Name: (Last, First, Middle)	DOB:	AGE:
Address:		City:	State:	Zip Code:
Home Phone:		SEX:		Patient's SSN:

Other family members treated? ☐ Yes ☐ No if Yes, Name(s) & Relationship:

Referred by PCP ☐ Yes ☐ No Referred by Someone other than PCP? ☐ Yes, ☐ No; if Yes, Name:

PCP Name:	Phone: Fax:	City of Practice:

RESPONSIBLE PARTIES

Patient Lives With: ☐ Father ☐ Mother ☐ Other (Name-Relationship)

Father Name: Last:	First:	Middle:	DOB:

Address/Phone Same as Patient? ☐ Yes ☐ No

If No: Address:	City:	State:	Zip:
Home Phone:	Mobile Phone:		SSN:
Employer:			Emp. Phone#

Mother Name: Last	First	Middle	DOB:

Address/Phone Same as Patient? ☐ Yes ☐ No

If No: Address:	City:	State:	Zip:
Home Phone:	Mobile Phone:		SSN:
Employer:	Occupation:		Emp. Phone#

PRIMARY INSURANCE

Is patient a fulltime student in secondary education on parent's insurance? ☐ **Yes** ☐ **No**

Name of Insurance Company:	Id/Member #:	Group#:
Policy Holder's Name:	Policy Holder's DOB	Member/Customer Service Phone #:
Referral Required? ☐ Yes ☐ No	**If yes, did you obtain one from your PCP?** ☐ Yes ☐ No	

EMERGENCY CONTACT

Contact must be other than parent(s):

Name of Contact:	Relationship to patient:	Home #:
Address:	City/State	Cell Phone #:

I hereby authorize Andrew L. Nash, M.D., a Medical Corp., to release any information acquired in the course of my treatment to my insurance company, employer, or third party payer as required for claims filed, quality assurance, health plan administration, or complaints/grievances. I understand that the specific information to be released may include, but is not limited to history, diagnosis and/or treatment of all related illnesses including HIV virus and Acquired Immune Deficiency Syndrome (AIDS). I authorize direct payment to be made to Andrew L. Nash, M.D., a Medical Corp., for any and all medical or surgical services rendered. I understand that if any services or charges are not covered, or if Andrew L. Nash, M.D., a Medical Corp., is unable to verify eligibility, that I am responsible for all charges incurred for services rendered.
I hereby voluntarily consent to such healthcare encompassing diagnostic procedures and treatment by Andrew L. Nash, M.D., a Medical Corp., as may be necessary in his judgment. I have relied on my physician for information in this regard and acknowledge that no warranty or guarantee has been made to me as a result or cure. This form has been fully explained to me, and I certify that I understand its contents.

_____

Signature & Relationship to Patient

epic care

Partners in Comprehensive Care

TERMS & CONDITIONS OF SERVICE

Thank you for choosing Epic Care for your medical needs. We are committed to providing you with the highest quality healthcare. Please read and sign this form to acknowledge your understanding of our Terms and Conditions of Service.

1. MEDICAL CONSENT

I, the undersigned patient or legal guardian, consent to the general treatment and procedures that may be performed. These procedures may include but are not limited to laboratory procedures, x-ray examinations, medical or surgical treatments or procedures provided to the patient under the general and special instructions of the patient's physician or surgeon. I understand that it is the responsibility of the patient's physician to obtain the patient's informed consent when required when required for specific medical or surgical treatment and special diagnostic or therapeutic procedures. I understand and agree that at the request of the attending physician, health practitioners (such as physician assistant and nurse practitioners) may participate in the patient's care.

2. FINANCIAL AGREEMENT

For the service(s) to be rendered, I agree to accept full financial responsibility for the patient's account in accordance with the regular rules and terms of Epic Care. This includes financial responsibility for all deductibles and co-payments that may be required by the patient's insurance. This also includes services or supplies not covered by the patient's insurance and or Medicare. There is also a $25 service fee for returned checks and a $50 no show fee. Should the patient's account(s) be referred to a collection agency or an attorney, I further agree to pay actual attorney's fees incurred in addition to other amounts due. When the service(s) to be billed to insurance, a health plan or another payment source, paragraphs 3 (Contracted Health Plan Patients and other Sources) and 5 (Assignment of Insurance Benefits) will also apply.

3. CONTRACTED HEALTH PLANS PATIENTS AND OTHER SOURCES

I understand that the patient may be eligible for certain health care coverage through a health plan (HMO, PPO) on the list of health plans with which Epic Care contracts, or through some other source (e.g., clinical trial sponsor, employer's workers' compensation insurance). I agree to be responsible under paragraph 2 (Financial Agreement) for paying the patient's account: (a) if Epic Care does not contract with the health plan; (b) for any co-payments and deductibles; (c) for services not approved by the health plan or other source (d) for services not covered and/or paid for by the patient's health plan or other source to the extent allowed by law or contract.

4. ASSIGNMENT OF INSURANCE BENEFITS (INCLUDING MEDICARE BENEFITS)

I, authorize direct payment to Epic Care of any insurance benefits otherwise payable to or on behalf of the patient for services, at a rate not to exceed the actual charges. I understand and agree that I am financially responsible under paragraph 2 (Financial Agreement) for charges not paid in accordance with this assignment.
I hereby give lifetime authorization for payment of insurance benefits to be made directly to Epic Care, and any assisting physicians, for services rendered.

The undersigned certified that he/she has read the Terms and Conditions of Service, has received a copy of it, and is the patient or a duly authorized by or on behalf of the patient to execute and accept its terms.

Patient Or Legally Authorized Individual's Signature	**Date**
Print Name	**(If Signed On Behalf Of Patient) Relationship To Patient**

ASSIGNMENTS OF BENEFITS

I hereby assign medical and/or surgical payments to include major medical benefits to which I am entitled, private insurance and any other health plan to Andrew L. Nash, M.D., a medical corporation, for services provided by Andrew L. Nash, M.D.
I understand if claims are denied due to eligibility status, invalid medical group or invalid Primary Care Physician (PCP), I will assume full responsibility for all charges incurred by me and all dependents for services, which have been provided to me.
This assignment will remain in effect until revoked by me in writing. A photocopy of the assignment is to be considered as valid as an original.

SIGNED: _____ DATE: _____

FINANCIAL POLICY

Insurance/Cash Payments:
Patients are financially responsible for services provided and are expected to pay at the time of service. We will courtesy bill your insurance, however you will need to provide complete billing information at the time of your visit. A copy of your charges, if requested, will be supplied to you so that you may follow up with your insurance company personally.

HMO/PPO Patients:
If you are a member of HMO/PPO health plan, you are required to pay a co-payment at the time of your visit. We cannot waive the co-payment amount as a contracted provider. Co-payments will be collected at the time of service. Non-covered services must be paid at the time of service.

Late / Cancellations / Appointment No-Shows:
If you arrive late for your appointment, your physician or nurse practitioner will be notified. It will be up to the provider to decide if they are still able to complete your visit, or if you will need to reschedule your appointment.

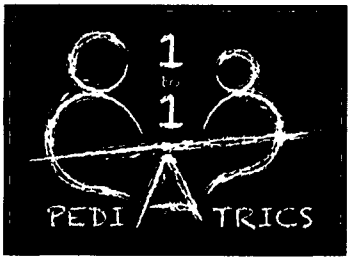
If you have a scheduled appointment and are unable to keep your appointment, please contact our office as soon as possible to cancel your appointment. *Please note: if you cancel or reschedule with less than 8 business hours notice (8 business hours = 1 business day), you will be charged a fee.

A missed appointment is recorded in your chart unless it is cancelled in advance, otherwise a fee will be charged depending on the appointment type. It is within the physicians discretion to dismiss you from the practice if you've had repeated cancellations or no-show appointments.

Charges for Completion of Forms and Photo Copying of Medical Records:
There is a charge for completion of forms and photo copying of medical records.

Payment Method
For your convenience, we accept VISA/MasterCard/Amex as well as cash and personal checks. Please make your checks payable to Andrew L. Nash, MD. A $25.00 charge will be applied on all returned checks.

NAME: _____ DATE: _____
I acknowledge I have read the above financial policy. 5/13/14



911 San Ramon Valley Blvd., Suite 100
Danville, CA 94526
(925) 362-1861

Email Disclaimer

1.) Please be advised that communicating via email is not secure communication. By return receipt of this email disclaimer you understand the potential risks inherent with email communication and agree to accept the possible risks and use email communication as a way for you and this office to communicate.

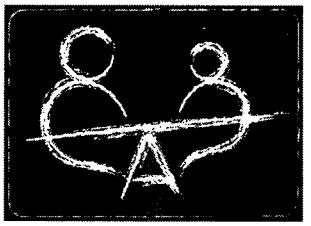
2.) I understand **Andrew L. Nash, MD., a medical corporation,** does not and cannot guarantee the confidentiality of any email communications and will not be liable for improper disclosure of confidential information and/or breaches in confidentially caused by me or a third party. I understand **Andrew L. Nash, MD., a medical corporation**, has no control over the security or management of my individual email service provider and cannot guarantee that information will not be intercepted, altered, or read by an unintended recipient.

Print Name: _____

Signature: _____

Date: _____

EMAIL ADDRESS: _____



Andrew L. Nash, M.D.,
A Medical Corporation

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY POLICY

By signing this form, you acknowledge the receipt of the Notice of Privacy Practices of Andrew L. Nash, M.D., A Medical Corporation. Our Notice of Privacy Practices provides information about how we may use and disclose your Protected Health Information (PHI). We encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. If we change our notice, we will provide you with the revised notice or you may obtain a copy of the revised notice by accessing our website at www.DrNashOnline.com or contacting our office at (925) 362-1861.

If you have any questions about our Notice of Privacy Practices, please contact the Privacy Official, Andrew L. Nash, M.D. at the office.

I have been provided a copy of the document Notice of Privacy Policy. I have read it and had any questions answered to my satisfaction.

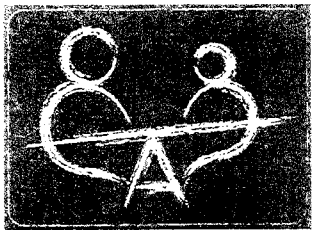
_____ _____

Patient Name Signature

Date of Birth_____

_____ _____

Parent/Guardian (if under 18 years of age) Date



NOTICE OF PRIVACY PRACTICES

Andrew L. Nash, MD, a Medical Corporation
911 San Ramon Valley Blvd., Suite 100
Danville, CA 94526

Andrew L. Nash, MD – (925) 362-1861

Effective Date: September 23, 2013

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.

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices with respect to protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our Privacy Officer listed above.

A. How This Medical Practice May Use or Disclose Your Health Information

This medical practice collects health information about you and stores it in a chart and on a computer. This is your medical record. The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

1. **Treatment.** We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services which we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured.

2. **Payment.** We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.

3. **Health Care Operations.** We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and

improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our "business associates," such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them to protect the confidentiality and security of your medical information. Although federal law does not protect health information which is disclosed to someone other than another healthcare provider, health plan, healthcare clearinghouse, or one of their business associates, California law prohibits all recipients of healthcare information from further disclosing it except as specifically required or permitted by law. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their patient-safety activities, their population- based efforts to improve health or reduce health care costs, protocol development, case management or care coordination activities, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, their activities related to contracts of health insurance or health benefits, or their health care fraud and abuse detection and compliance efforts

4. **Appointment Reminders**. We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.
5. **Sign In Sheet.** We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.
6. **Notification and Communication with Family**. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or, unless you have instructed us otherwise, in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.
7. **Marketing**. Provided we do not receive any payment for making these communications, we may contact you to encourage you to purchase or use products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments, therapies, health care providers or settings of care that may be of interest to you. We may similarly describe products or services provided by this practice and tell you which health plans we participate in,
   We may receive financial compensation to talk with you face-to-face, to provide you with small promotional gifts, or to cover our cost of reminding you to take and refill your medication or otherwise communicate about a drug or biologic that is currently prescribed for you, but only if you either: (1) have a chronic and seriously debilitating or life-threatening condition and the communication is made to educate or advise you about treatment options and otherwise maintain adherence to a prescribed course of treatment, or (2) you are a current health plan enrollee and the communication is limited to the availability of more cost-effective pharmaceuticals. If we make these communications while you have a chronic and seriously debilitating or life threatening condition, we will provide notice of the following in at least 14-point type: (1) the fact and source of the remuneration; and (2) your right to opt-out of future remunerated communications by calling the communicator's toll-free number. We will not otherwise use or disclose your medical information for marketing purposes or accept any payment for other marketing communications without your prior written authorization. The authorization will disclose whether we receive any

financial compensation for any marketing activity you authorize, and we will stop any future marketing activity to the extent you revoke that authorization.

8. **Sale of Health Information**. We will not sell your health information without your prior written authorization. The authorization will disclose that we will receive compensation for your health information if you authorize us to sell it, and we will stop any future sales of your information to the extent that you revoke that authorization.
9. **Required by Law**. As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.
10. **Public Health.** We may, and are sometimes required by law to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.
11. **Health Oversight Activities**. We may, and are sometimes required by law to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by federal and California law.
12. **Judicial and Administrative Proceedings**. We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.
13. **Law Enforcement**. We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying of locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.
14. **Coroners**. We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.
15. **Organ or Tissue Donation**. We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.
16. **Public Safety**. We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.
17. **Proof of Immunization**. We will disclose proof of immunization to a school where the law requires the school to have such information prior to admitting a student if you have agree to the disclosure on behalf of yourself or your dependent.
18. **Specialized Government Functions**. We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.
19. **Worker's Compensation**. We may disclose your health information as necessary to comply with worker's compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.
20. **Change of Ownership**. In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.

21. **Breach Notification**. In the case of a breach of unsecured protected health information, we will notify you as required by law. If you have provided us with a current email address, we may use email to communicate information related to the breach. In some circumstances our business associate may provide the notification. We may also provide notification by other methods as appropriate
22. **Psychotherapy Notes**. We will not use or disclose your psychotherapy notes without your prior written authorization except for the following: (1) your treatment, (2) for training our staff, students and other trainees, (3) to defend ourselves if you sue us or bring some other legal proceeding, (4) if the law requires us to disclose the information to you or the Secretary of HHS or for some other reason, (5) in response to health oversight activities concerning your psychotherapist, (6) to avert a serious threat to health or safety, or (7) to the coroner or medical examiner after you die. To the extent you revoke an authorization to use or disclose your psychotherapy notes, we will stop using or disclosing these notes.
23. **Research**. We may disclose your health information to researchers conducting research with respect to which your written authorization is not required as approved by an Institutional Review Board or privacy board, in compliance with governing law.
24. **Fundraising**. We may use or disclose your demographic information, the dates that you received treatment, the department of service, your treating physician, outcome information and health insurance status in order to contact you for our fundraising activities. If you do not want to receive these materials, notify the Privacy Officer listed at the top of this Notice of Privacy Practices and we will stop any further fundraising communications. Similarly, you should notify the Privacy Office if you decide you want to start receiving these solicitations again.

B. When This Medical Practice May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, this medical practice will, consistent with its legal obligations, not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

C. Your Health Information Rights

1. **Right to Request Special Privacy Protections**. You have the right to request restrictions on certain uses and disclosures of your health information by a written request specifying what information you want to limit, and what limitations on our use or disclosure of that information you wish to have imposed. If you tell us not to disclose information to your commercial health plan concerning health care items or services for which you paid for in full out-of-pocket, we will abide by your request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any other request, and will notify you of our decision.

2. **Right to Request Confidential Communications**. You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular email account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.

3. **Right to Inspect and Copy**. You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to, whether you want to inspect it or get a copy of it, and if you want a copy, your preferred form and format. We will provide copies in your requested form and format if it is readily producible, or we will provide you with an alternative format you find acceptable, or if we can't agree and we maintain the record in an electronic format, your choice of a readable electronic or hardcopy format. We will also send a copy to another person you designate in writing. We will charge a reasonable fee which covers our costs for labor, supplies, postage, and if requested and agreed to in advance, the cost of preparing an explanation or summary, as allowed by federal and California law. We may deny your request under limited circumstances. If we deny your request to access your child's records or the records of an incapacitated adult you are representing because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision. If we deny your request to access your

psychotherapy notes, you will have the right to have them transferred to another mental health professional.

4. Right to Amend or Supplement. You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. If we deny your request, you may submit a written statement of your disagreement with that decision, and we may, in turn, prepare a written rebuttal. You also have the right to request that we add to your record a statement of up to 250 words concerning anything in the record you believe to be incomplete or incorrect. All information related to any request to amend or supplement will be maintained and disclosed in conjunction with any subsequent disclosure of the disputed information.

5. Right to an Accounting of Disclosures. You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 18 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.

6. You have a right to notice of our legal duties and privacy practices with respect to your health information, including a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by email.

If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer listed at the top of this Notice of Privacy Practices.

D. Changes to this Notice of Privacy Practices

We reserve the right to amend our privacy practices and the terms of this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with this Notice. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, post on our website and a copy will be available at each appointment.

E. Complaints

Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer listed at the top of this Notice of Privacy Practices.

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to:

Region IX
Office for Civil Rights
U.S. Department of Health & Human Services
90 7th Street, Suite 4-100
San Francisco, CA 94103
(415) 437-8310; (415) 437-8311 (TDD)
(415) 437-8329 FAX
OCRMail@hhs.gov

The complaint form may be found at www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaint.pdf. You will not be penalized in any way for filing a complaint.