Date:___________

ASIAN PACIFIC HEALTH CARE VENTURE, INC.
"working together for community health"

Patient Registration

Patient Last Name	Patient First Name	Patient Middle Name
Social Security #	Date of Birth (mm/dd/yyyy)	Gender at birth: ☐ Male ☐ Female

Street address City State Zip	Are you transgender? ☐ Yes ☐ No If Yes, select: ☐ Trans- Male to Female or ☐ Trans–Female to Male
Is it Ok to send mail to your address? ☐ Yes ☐ No	Do you need an Interpreter? ☐ Yes ☐ No — Preferred language?
Home phone number: Cell phone number:	What is your marital status? (check one) ☐ Divorced ☐ Married ☐ Single ☐ Domestic partner ☐ Separated ☐ Widowed
Day phone number:	Student Status: (check one) ☐ Full time ☐ Part- time ☐ Not a student
Who is your Medical Provider?	Contact Preference: ☐ No Preference ☐ Phone ☐ Email/Patient Portal ☐ Mail
Preferred Phone number: ☐ Home ☐ Cell ☐ Day	Email Address: (please provide if you checked Email/Patient Portal as contact preference)
Birth Mother's Maiden Name (before marriage)	Birth Mother's *First* Name
Year you arrived in the United States? ______________ or N/A	Are you a veteran of US Armed Forces? ☐ Yes ☐ No
What is your highest Level of education completed? (check one) ☐ Elementary ☐ Junior High School ☐ High School ☐ College ☐ Graduate Degree or Higher ☐ N/A	
Citizenship: ☐ U.S. ☐ Permanent Resident ☐ Tourist ☐ Other	Do you have a physical or mental disability that has prevented or will prevent you from working for more than a year? ☐ Yes ☐ No

INCOME INFORMATION
(Required for APHCV funding)

How many people in your family? (Yourself, spouse & minor children under 18 years)	What is your household annual income? (Income of the persons listed in your family, if they are working)

EMERGENCY CONTACT INFORMATION

Emergency contact: (spouse, friend, Legal Guardian or Parent) Last Name: First Name:	Relationship to patient:	Phone: ( ) - ☐ Home ☐ Work ☐ Cell

GUARANTOR INFORMATION
(Parent or Legal Guardian for Children under 18 years)

PARENT/LEGAL GUARDIAN 1			PARENT/LEGAL GUARDIAN 2		
Last Name	First Name	Middle Name	Last Name	First Name	Middle Name
Address		City	Address		City
State Zip	Gender: ☐ Male ☐ Female		State Zip	Gender: ☐ Male ☐ Female	
Date of Birth (mm/dd/yyyy) Phone Number:	Relationship to patient : ☐ Parent ☐ Foster parent ☐ Step parent ☐ Other _______		Date of Birth (mm/dd/yyyy) Phone Number:	Relationship to patient : ☐ Parent ☐ Foster parent ☐ Step parent ☐ Other _______	

How did you hear about our clinic? (Please circle all that apply)

APHCV Employee	Brochure/Flyer	Fair/Festival/Event	Internet-Google/Yahoo/Etc. Search
Ad-Billboard/Bus	Building Sign	Hospital/Doctor	Internet-Yelp/Health Grades
Ad-Newspaper/Magazine	Family	Internet-APHCV website	Patient
Ad-TV/Radio	Friend	Internet-Advertisement	School

Asian Pacific Health Care Venture, Inc.
"working together for community health"

Dear Patient,

In order to continue the variety of services that we offer here at APHCV and to continue to receive grant funding, we are required to collect the following information on every person that visits our facility. This information is reported as a number and not as individual patients.

Please take a few minutes to complete the following information request:

1. Please select all apply from the following race listing:
   - ☐ Asian
   - ☐ Black/African American
   - ☐ Other Pacific Islander
   - ☐ Native Hawaiian
   - ☐ American Indian/Alaska Native
   - ☐ White
   - ☐ More than one Race

2. Please select one of the following from the ethnicity listing:
   - ☐ Hispanic
   - ☐ Not Hispanic

3. Please select one from the additional categories so that we have information that represents you and your family:
   - ☐ Armenian
   - ☐ Asian Indian
   - ☐ Bangladeshi
   - ☐ Cambodian
   - ☐ Central America
   - ☐ Chinese
   - ☐ Cuban
   - ☐ Indonesian
   - ☐ Japanese
   - ☐ Korean
   - ☐ Laotian
   - ☐ Mexican
   - ☐ Pilipino
   - ☐ Puerto Rican
   - ☐ South American
   - ☐ Sri Lankan
   - ☐ Thai
   - ☐ Vietnamese
   - ☐ White
   - ☐ Other: ____________

4. Birthplace:
   - ☐ Armenia
   - ☐ Bangladesh
   - ☐ Cambodia
   - ☐ China
   - ☐ El Salvador
   - ☐ Guatemala
   - ☐ Indonesia
   - ☐ Japan
   - ☐ Korea
   - ☐ Laos
   - ☐ Mexico
   - ☐ Philippines
   - ☐ Thailand
   - ☐ United States
   - ☐ Vietnam
   - ☐ Other:___________

5. Have you or any family members done agriculturally related work in the last 3 years?
   ☐ Yes ☐ No

   a. **If yes**, was it <u>migrant farm work</u> in which you travel from town to town without establishing a permanent residence?
   ☐ Yes ☐ No

   b. **If yes**, was it <u>seasonal farm work</u> in which you travel and work seasonally and have an established residence in the same area?
   ☐ Yes ☐ No

6. Are you Homeless?
   ☐ Yes ☐ No

   a. **If yes**, where did you stay/sleep last night?
   - ☐ Homeless shelter
   - ☐ Transitional Housing
   - ☐ Street
   - ☐ Car or other Vehicle
   - ☐ Other
   - ☐ Hotel/Motel
   - ☐ Unknown

Thank you for providing this information to APHCV. This will ensure that we are able to provide you with valuable services and programs in the future.

Revised 08/2016-English

(SBHC use only)
Parent verification by:
____
Date: ______________

Combined Consent

Patient Identifying Label

A. CONSENT TO TREATMENT:
I hereby request and consent to diagnostic procedures, tests, and medical treatment, family planning and immunizations as deemed advisable by the professional staff of Asian Pacific Health Care Venture, Inc. (APHCV, Inc.). I am aware that a Physician, a Nurse Practitioner or a Physician Assistant may provide the medical care. Services will be in my best interest, or the best interest of my child or legal charge. I consent to the taking of photographs, videotapes, digital or other images of my medical condition or treatment by clinical staff, and the use of the images for purposes of my diagnosis or treatment or for the clinic's operations including peer review, education and training programs conducted by the clinic. A separate consent is required by me for use of image for non-clinical purposes. I understand that this consent to treatment will be in effect as long as I am seen at any of the Asian Pacific Health Care Venture, Inc. clinic sites. I may cancel this consent in writing. The consent must be cancelled for each clinic that I am seen in.

B. AUTHORIZATION FOR MEDICAL RECORDS RELEASE/REFERRAL AND ASSIGNMENT OF BENEFITS:
I authorize APHCV, Inc. to release medical/social information to persons or agencies directly concerned with and engaged in carrying out a treatment plan for the patient. Also APHCV, Inc. may use and release any part of my medical records necessary to the process of billing third party payers for services rendered on my behalf. I clearly understand that all my information will be kept confidential. I understand that this information will be used to review, investigate, or make payment of a claim, and to review records for quality improvement initiatives, audit compliance, utilization management, and complaint resolution.

I authorize payment directly to Asian Pacific Health Care Venture, Inc. for all medical benefits otherwise payable to me under terms of my insurance. I understand that I am financially responsible for all co-payments, co-insurance, deductibles, and non-covered services. Overpayments on any Asian Pacific Health Care Venture, Inc. account may be applied to my patient balance within the Asian Pacific Health Care Venture, Inc., sites. A photocopy of this authorization shall be considered as effective and as valid as the original.

C. PROTECTED HEALTH INFORMATION DESIGNEE:
I understand that the individuals identified below will be treated by Asian Pacific Health Care Venture, Inc. (APHCV), as individuals involved directly in *my care or my child's care*, and as such APHCV will be allowed to communicate, discuss and release the patient protected health information related to the health care services I or my child receive at APHCV. I understand that the information that can be released are limited to the following: Appointment/Procedure (scheduling, rescheduling, cancelling), Prescription re-fill(s), Laboratory test results, Radiology Examination Results, Referral Inquiries, Billing Inquiries.

Name of Designee: ____________________ Designee Date of Birth: ____________

Designee Phone Number: ____________________ Relationship to Patient: ____________

Name of Designee: ____________________ Designee Date of Birth: ____________

Designee Phone Number: ____________________ Relationship to Patient: ____________

☐ I *decline to provide a protected health information designee contact for myself or my child at this time.*

Patient/Parent/Legal Guardian Signature **(Please circle one)** ____________________ Date: ____________

D. ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES:

- I acknowledge that I received the Notice of Privacy Practices from Asian Pacific Health Care Venture, Inc.
- You also have the right to request to be contacted at a different location or by a different method.

APHCV will agree to any reasonable request for alternative methods of contact. If you would like to request an alternative method of contact, please provide the contact information below:

____

Street Address City State Zip code

Alternative Telephone: ____________________

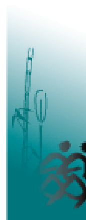
Signed: **X**____________________ ____________

Patient/Parent/Legal Guardian Signature **(Please circle one)** Date

Please print full name and relationship to patient if the patient cannot sign this document.

____

Full name (Print name of **Parent or Legal Guardian**) Relationship



PATIENT FINANCIAL POLICY

(Updated June 2016)

PAYMENT RESPONSIBILITY POLICY
(Financial Policy)

The following is our Patient Financial Policy.

1. Payment is expected in full when services are rendered.

2. Medi-Cal and/or Medicare
If you have Medi-Cal and/or Medicare, please provide us with your current Medi-Cal and/or Medicare Card at each visit. If you have a share of cost, you will be asked to pay that amount at the time of service. **All co-pays, co-insurances, and share of cost are due at time of service**. If your Medi-Cal and/or Medicare claim is denied, you are fully responsible for the cost of the service.

3. Private Insurance
If you have private insurance that we can accept, please provide us with a copy of your insurance card at each visit. **All co-pays, non-covered services and deductibles are due at time of service**. If your health insurance claim is denied, you are fully responsible for the cost of the service.

4. Self Pay Patients
Full payment is due at time of service. We accept CASH, CHECKS, CREDIT/DEBIT CARDS. We offer a sliding fee discount and prompt payment incentive if you qualify. Please ask the Front Office staff for additional information.

5. LAUSD students at school-based health centers
Upon the agreement with Los Angeles Unified School District, APHCV shall not charge fees to pre K – 12 students accessing services at school based health centers. APHCV shall charge all other populations as appropriate.

6. Government Funded Programs
We offer several different government funded programs for which you may qualify. If you would like more information, please ask our Front Office staff. Fee for services out of the scope of benefit of government funded program is Patient's responsibility.

Thank you for choosing us as your health care provider. Please let us know if you have questions or concerns. By signing below you acknowledge and accept our Patient Financial Policy.

X____Date____________________
Signature of Patient or Responsible Party

X____Date____________________
Signature of Co-Responsible Party

Place Patient label here

PATIENT SAFETY AGREEMENT

At Asian Pacific Health Care Venture, Inc. (APHCV) we do our best to provide a safe place for our patients and visitors to get quality medical care. Therefore, we ask patients and visitors to agree to the following:

1. **RESPECT OTHER CLIENTS AND STAFF:** I promise to respect the privacy and personal safety of all clients and staff of the clinic. I understand that any form of violence or aggressive behavior such as yelling, shouting, hitting, pushing, etc. will not be tolerated. I shall not steal nor vandalize APHCV property (including graffiti).

2. **NO WEAPONS:** I and anyone who comes with me (friends or family) shall not bring weapons of any kind into the clinic area at any time. I understand that if I bring a weapon such as guns, knives, stun guns or any other type of weapon into the clinic I may be asked to leave. I may also be transferred to another facility for my care. If I am legally permitted to carry a weapon (e.g., if you are a peace officer) I shall tell the front desk when I check in.

3. **NO CRIMINAL ACTS:** I shall not do any criminal acts while at APHCV. I understand that APHCV holds right to report any illegal activities to the authorities.

4. **WATCH MY CHILDREN AND BELONGINGS:** I shall supervise and regulate any family members and visitors, in particular children, who may come with me to the clinic. I am also responsible in watching my belongings at all times.

5. **ACCEPTING CONSEQUENCES:** I understand the above responsibilities and will follow them to the best of my ability. I understand that the violation of the above expectations may result in refusal or termination of care at APHCV.

APHCV Administrative Office | 4216 Fountain Avenue | Los Angeles, California 90029 | 323.644.3880 | www.aphcv.org

Belmont Health Center
180 Union Place
Los Angeles, California 90026
323.644.3885

El Monte/Rosemead Health Center
9960 Baldwin Place
El Monte, California 91731
626.774.2988

John Marshall High School Health Center
3939 Tracy Street
Los Angeles, California 90027
323.665.1129

Los Feliz Health Center
1530 Hillhurst Avenue
Los Angeles, California 90027
323.644.3888

Place Patient label here

PATIENT RESPONSIBILITIES

Asian Pacific Health Care Venture, Inc. (APHCV) and its staff work with patients in order for them to receive quality and effective medical care, to achieve this goal, we ask all patients to be informed and agree to the following patient responsibilities. **Please place your initials after reading each statement next to the provided space.**

1. **PROVIDE INFORMATION:** I shall provide true and complete information about my past and current illnesses, hospitalizations, medications and other matters relating to my health and answer any questions related to it, to the best of my knowledge. I shall provide up-to-date contact information so that APHCV has a way to contact me when it is necessary. Initial _____
2. **ASK QUESTIONS:** I shall ask questions about my health problems and treatment if they are not clear to me. Initial ______
3. **CALL FOR APPOINTMENT:** If I am feeling bad or have a question about my health care, I will call the clinic. If I feel I need to come into the clinic for medical care, case management, social services, or prescription refills, I will call first. If appointments are not available, I can walk-in to the clinic without an appointment. As a walk-in, I understand I may have to wait for an appointment and a same day appointment is not guaranteed. Initial _____
4. **KEEP MY APPOINTMENT:** I shall keep all my scheduled appointments and arrive on time. If I cannot keep my appointment, I will call the clinic and cancel my appointment at least 24 hours before my appointment time. I shall arrive about 20 or 40 minutes prior to my scheduled appointment, depending on my appointment and/or insurance program renewal if needed, to allow enough time to complete my check-in process. *I understand my appointment will be cancelled, re-scheduled or moved to another time if I arrive after my given scheduled check-in time*. Initial _________
5. **RESPONSIBLE FOR MY CARE:** I understand that I am ultimately responsible for my own health care and for that of my family. It is my responsibility to make and keep appointments for treatment of diseases or conditions and preventative care such as health check-ups, immunizations, pap smears, mammograms, or HIV tests. I understand that I am responsible for the outcomes if I do not follow the instructions of health care providers. Initial _________
6. **INDIVIDUALS WITH DISABILITIES USING SERVICE ANIMALS**: I understand that I am responsible for the care and supervision of my service animal at all times, which includes leashing, toileting, cleaning up and disposal of animal waste, feeding. I understand that APHCV may require a service animal to be removed from the clinic immediately if APHCV finds any of the following; (a) the service animal is disruptive, out of control; or (b) the service animal causes any harm to patients/staff. Initial _________

I have read, understood, and agreed to adhere to both the Patient Safety Agreement and the Patient Responsibilities.

____ ____________________

Patient/Parent/Legal Guardian Signature **(Please circle one)** Date

____

Print Name

APHCV Administrative Office | 4216 Fountain Avenue | Los Angeles, California 90029 | 323.644.3880 | www.aphcv.org

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NOTICE OF PRIVACY PRACTICES

This Notice is effective 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

WE ARE REQUIRED BY LAW TO PROTECT MEDICAL INFORMATION ABOUT YOU

We are required by law to protect the privacy of medical information about you and that identifies you. This medical information may be information about healthcare we provide to you or payment for healthcare provided to you. It may also be information about your past, present, or future medical condition.

We are also required by law to provide you with this Notice of Privacy Practices explaining our legal duties and privacy practices with respect to medical information. We are legally required to follow the terms of this Notice. In other words, we are only allowed to use and disclose medical information in the manner that we have described in this Notice.

We may change the terms of this Notice in the future. We reserve the right to make changes and to make the new Notice effective for *all* medical information that we maintain. If we make changes to the Notice, we will:

- Post the new Notice in our waiting area.
- Have copies of the new Notice available upon request. To obtain a copy of our current Notice, please contact our Clinic Manager, Front Office staff or Privacy Officer, Mika Aoki or Junior Privacy Officer, Jeff Wongsiriyanon at (323) 644-3880, extension 235.
- You may obtain an electronic copy at our website: www.aphcv.org

The rest of this Notice will:

- Discuss how we may use and disclose medical information about you.
- Explain your rights with respect to medical information about you.
- Describe how and where you may file a privacy-related complaint.

If, at any time, you have questions about information in this Notice or about our privacy policies, procedures or practices, you can contact our Clinic Manager on site or Privacy Officer, Mika Aoki or Junior Privacy Officer, Jeff Wongsiriyanon at (323) 644-3880, extension 235.

We use and disclose medical information about patients every day. This section of our Notice explains in some detail how we may use and disclose medical information about you in order to provide healthcare, obtain payment for that healthcare, and operate our business efficiently. This section then briefly mentions several other circumstances in which we may use or disclose medical information about you. For more information about any of these uses or disclosures, or about any of our privacy policies, procedures or practices, contact our Privacy Officer, Mika Aoki or Junior Privacy Officer, Jeff Wongsiriyanon at (323) 644-3880, extension 235.

1. Treatment

We may use and disclose medical information about you to provide healthcare treatment to you. In other words, we may use and disclose medical information about you to provide, coordinate or manage your healthcare and related services or recommend possible treatment options or alternatives. This may include communicating with other healthcare providers regarding your treatment and coordinating and managing your healthcare with others.

Example: Jane is a patient at Asian Pacific Health Care Venture, Inc. The receptionist may use medical information about Jane when setting up an appointment. The doctor will likely use medical information about Jane when reviewing Jane's condition and ordering a blood test. The laboratory technician will likely use medical information about Jane when processing or reviewing her blood test results. If, after reviewing the results of the blood test, the doctor concludes that Jane should be referred to a specialist, the nurse may disclose medical information about Jane to the specialist to assist the specialist in providing appropriate care to Jane.

2. Payment
We may use and disclose medical information about you to obtain payment for healthcare services that you received. This means that, within Asian Pacific Health Care Venture, Inc, we may *use* medical information about you to arrange for payment (such as preparing bills and managing accounts). We also may *disclose* medical information about you to others (such as insurers, collection agencies, and consumer reporting agencies). In some instances, we may disclose medical information about you to an insurance plan *before* you receive certain healthcare services because, for example, we may need to know whether the insurance plan will pay for a particular service.

Example: Jane is a patient at Asian Pacific Health Care Venture, Inc and she has private insurance. During an appointment with a doctor, the doctor ordered a blood test. Asian Pacific Health Care Venture, Inc.'s billing clerk will *use* medical information about Jane when he prepares a bill for the services provided at the appointment and the blood test. Medical information about Jane will be *disclosed* to her insurance company when the billing clerk sends in the bill.

Example: The doctor referred Jane to a specialist. The specialist recommended several complicated and expensive tests. The specialist's billing clerk may contact Jane's insurance company before the specialist runs the tests to determine whether the plan will pay for the test.

3. Healthcare Operations
We may use and disclose medical information about you in performing a variety of business activities that we call "healthcare operations." These "healthcare operations" activities allow us to, for example, improve the quality of care we provide and reduce healthcare costs. For example, we may use or disclose medical information about you in performing the following activities:

- Reviewing and evaluating the skills, qualifications, and performance of healthcare providers taking care of you.
- Providing training programs for students, trainees, healthcare providers or non-healthcare professionals to help them practice or improve their skills.
- Cooperating with outside organizations that evaluate, certify or license healthcare providers, staff or facilities in a particular field or specialty.
- Reviewing and improving the quality, efficiency and cost of care that we provide to you and our other patients.
- Improving healthcare and lowering costs for groups of people who have similar health problems and helping manage and coordinate the care for these groups of people.
- Cooperating with outside organizations that assess the quality of the care others and we provide, including government agencies and private organizations.
- Planning for our organization's future operations.
- Resolving grievances within our organization.
- Reviewing our activities and using or disclosing medical information in the event that control of our organization significantly changes.
- Working with others (such as lawyers, accountants and other specialty medical providers) who assist us to comply with this Notice and other applicable laws.

Example: Jane was diagnosed with diabetes. Asian Pacific Health Care Venture, Inc. used Jane's medical information – as well as medical information from all of the other medical provider patients diagnosed with diabetes – to develop an educational program to help patients recognize the early symptoms of diabetes. (Note: The educational program would not identify any specific patients without their permission).

Example: Jane complained that she did not receive appropriate healthcare. Asian Pacific Health Care Venture, Inc. reviewed Jane's record to evaluate the quality of the care provided to Jane. Asian Pacific Health Care Venture, Inc. also discussed Jane's care with the care team.

4. Persons Involved in Your Care
We may disclose medical information about you to a relative, close personal friend or any other person you identify if that person is involved in your care and the information is relevant to your care. Asian Pacific Health Care Venture, Inc. has made the Protected Health Information Designee Form available to all patients and legal guardians so that they may identify those individuals that could possible provide assistance in providing health care treatment to you or a minor child. Please ask for the Protected Health Information Designee form at the Front Office if you are unsure that you provided this information at registration. If the patient is a minor, we may disclose medical information about the minor to a parent, guardian or other person responsible for the minor except in limited circumstances. Please review minor consent pamphlet available at the Clinic Front Office. For more information on the privacy of minors' information, contact our Clinic Manager on site or Privacy Officer, Mika Aoki or Junior Privacy Officer, Jeff Wongsiriyanon or designee at (323) 644-3880, extension 235.

We may also use or disclose medical information about you to a relative, another person involved in your care or possibly a disaster relief organization (such as the Red Cross) if we need to notify someone about your location or condition.

You may ask us at any time not to disclose medical information about you to persons involved in your care. It is the policy of APHCV that you would need to revise your Protected Health Information Designee Form to exclude those individuals that you no longer what to be involved in your or your child's health care treatment or decline to have a protected health information designee contact. We will agree to your request and not disclose the information except in certain limited circumstances (such as emergencies) or if the patient is a minor. If the patient is a minor, we may or may not be able to agree to your request.

Example: Jane signs the PHI designee form and assigns her husband to be a PHI designee. Jane's husband regularly comes to Asian Pacific Health Care Venture, Inc. with Jane for her appointments and he helps her with her medication. When the doctor is discussing a new medication with Jane, Jane invites her husband to come into the private room. The doctor discusses the new medication with Jane and Jane's husband.

5. Required by Law
We will use and disclose medical information about you whenever we are required by law to do so. There are many state and federal laws that require us to use and disclose medical information. For example, state law requires us to report gunshot wounds and other injuries to the police and to report known or suspected child abuse or neglect to the Department of Social Services. We will comply with those state laws and with all other applicable laws.

6. National Priority Uses and Disclosures
When permitted by law, we may use or disclose medical information about you without your permission for various activities that are recognized as "national priorities." In other words, the government has determined that under certain circumstances (described below), it is so important to disclose medical information that it is acceptable to disclose medical information without the individual's permission. We will only disclose medical information about you in the following circumstances when we are permitted to do so by law. Below are brief descriptions of the "national priority" activities recognized by law. For more information on these types of disclosures, contact our Privacy Officer, Mika Aoki or Junior Privacy Officer, Jeff Wongsiriyanon at (323) 644-3880, extension 235.

- **Threat to health or safety:** We may use or disclose medical information about you if we believe it is necessary to prevent or lessen a serious threat to health or safety of general public.
- **Public health activities:** We may use or disclose medical information about you for public health activities. Public health activities require the use of medical information for various activities, including, but not limited to, activities related to investigating diseases, reporting child abuse and neglect, monitoring drugs or devices regulated by the Food and Drug Administration, and monitoring work-related illnesses or injuries. For example, if you have been exposed to a communicable disease (such as a sexually transmitted disease), we must report it to the County of Los Angeles and take other actions to prevent the spread of the disease.
- **Abuse, neglect or domestic violence:** We may disclose medical information about you to a government authority (such as the Department of Social Services) if you are an adult and we reasonably believe that you may be a victim of abuse, neglect or domestic violence.
- **Health oversight activities:** We may disclose medical information about you to a health oversight agency – which is basically an agency responsible for overseeing the healthcare system or certain government programs. For example, a government agency may request information from us while they are investigating possible insurance fraud.
- **Court proceedings:** We may disclose medical information about you to a court or an officer of the court (such as an attorney). For example, we would disclose medical information about you to a court if a judge orders us to do so.

- **Law enforcement:** We may disclose medical information about you to a law enforcement official for specific law enforcement purposes. For example, we may disclose limited medical information about you to a police officer if the officer needs the information to help find or identify a missing person.
- **Coroners and others:** We may disclose medical information about you to a coroner, medical examiner, or funeral director or to organizations that help with organ, eye and tissue transplants.
- **Workers' compensation:** We may disclose medical information about you in order to comply with workers' compensation laws.
- **Research organizations:** We may use or disclose medical information about you to research organizations if the organization has satisfied certain conditions about protecting the privacy of medical information.
- **Certain government functions:** We may use or disclose medical information about you for certain government functions, including but not limited to military and veterans' activities and national security and intelligence activities. We may also use or disclose medical information about you to a correctional institution in some circumstances.

7. Authorizations

Other than the uses and disclosures described above (#1-6), we will not use or disclose medical information about you without the "authorization" – or signed permission – of you or your personal representative. In some instances, we may wish to use or disclose medical information about you and we may contact you to ask you to sign an authorization form. In other instances, you may contact us to ask us to disclose medical information and we will ask you to sign an authorization form.

If you sign a written authorization allowing us to disclose medical information about you, you may later revoke or cancel your authorization in writing (except in very limited circumstances related to obtaining insurance coverage). If you would like to revoke your authorization prior to expiration date as indicated on the authorization form (or 1 year from the date signed), you may write us a letter revoking your authorization. If you revoke your authorization, we will follow your instructions except to the extent that we have already relied upon your authorization and taken some action.

The following uses and disclosures of your or your child's medical information will only be made with your authorization (signed permission):

- Uses and disclosures for marketing purposes.
- Uses and disclosures that constitute the sales of medical information about you.
- Most uses and disclosures of psychotherapy notes, if we maintain psychotherapy notes.
- Any other uses and disclosures not described in this Notice.

YOU HAVE RIGHTS WITH RESPECT TO MEDICAL INFORMATION ABOUT YOU

You have several rights with respect to medical information about you. This section of the Notice will briefly mention each of these rights. If you would like to know more about your rights, please contact our Clinic Manger on site, or Privacy Officer, Mika Aoki or Junior Privacy Officer, Jeff Wongsiriyanon at (323) 644-3880, extension 235.

1. Right to a Copy of This Notice

You have a right to have a paper copy of our Notice of Privacy Practices at any time. In addition, a copy of this Notice will always be posted in our waiting area. If you would like to have a copy of our Notice, ask the Front Office for a copy or contact our Privacy Officer, Mika Aoki or Junior Privacy Officer, Jeff Wongsiriyanon or designee at (323) 644-3880, extension 235.

2. Right of Access to Inspect and Copy

You have the right to inspect (which means see or review) and receive a copy of medical information about you that we maintain in certain groups of records. If we maintain your medical records in an Electronic Health Record (EHR) system, you may obtain an electronic copy of your medical records. You may also instruct us in writing to send an electronic copy of your medical records to a third party. If you would like to inspect or receive a copy of medical information about you, you must provide us with a request in writing. You may write us a letter requesting access.

We may deny your request in certain circumstances. If we deny your request, we will explain our reason for doing so in writing. We will also inform you in writing if you have the right to have our decision reviewed by another person.

If you would like a copy of the medical information about you, we will charge you a fee to cover the costs of the copy. Our fees for electronic copies of your medical records will be limited to the direct labor costs associated with fulfilling your request.

We may be able to provide you with a summary or explanation of the information. Contact our Medical Records Department at (323) 644-3880, extension 235 for more information on these services and any possible additional fees.

3. Right to Have Medical Information Amended

You have the right to have us amend (which means correct or supplement) medical information about you that we maintain in certain groups of records. If you believe that we have information that is either inaccurate or incomplete, we may amend the information to indicate the problem and notify others who have copies of the inaccurate or incomplete information. If you would like us to amend information, you must provide us with a request in writing and explain why you would like us to amend the information. You may either write us a letter requesting an amendment or fill out an **Amendment Request Form**. Amendment Request Forms are available at our Medical Records Department or from Medical Records Designated staff at each site.

We may deny your request in certain circumstances. If we deny your request, we will explain our reason for doing so in writing. You will have the opportunity to send us a statement explaining why you disagree with our decision to deny your amendment request and we will share your statement whenever we disclose the information in the future.

4. Right to an Accounting of Disclosures We Have Made

You have the right to receive an accounting (which means a detailed listing) of disclosures that we have made for the previous six (6) years. If you would like to receive an accounting, you may send us a letter requesting an accounting, fill out an **Accounting Request Form**, or contact our Privacy Officer or Junior Privacy Officer. Accounting Request Forms are available from Clinic Front Office, or Medical Records Department, or our Privacy Officer or Junior Privacy Officer.

The accounting will not include several types of disclosures, including disclosures for treatment, payment or healthcare operations. If we maintain your medical records in an Electronic Health Record (EHR) system, you may request the report to include disclosures for treatment, payment or healthcare operations. The accounting will also not include disclosures made prior to April 14, 2003.

If you request an accounting more than once every twelve (12) months, we may charge you a fee to cover the costs of preparing the accounting.

5. Right to Request Restrictions on Uses and Disclosures

You have the right to request that we limit the use and disclosure of medical information about you for treatment, payment and healthcare operations.

- 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.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say “yes” unless a law requires us to share that information.

6. Right to Request an Alternative Method of Contact

You have the right to request to be contacted at a different location or by a different method. For example, you may prefer to have all written information mailed to your work address rather than to your home address.

We will agree to any reasonable request for alternative methods of contact. If you would like to request an alternative method of contact, you must provide us with a request in writing. You may write us a letter or complete a patient registration form by requesting it from our Front Office Staff members.

7. Right to Notification if a Breach of Your Medical Information Occurs

You also have the right to be notified in the event of a breach of medical information about you. If a breach of your medical information occurs and if that information is unsecured (not encrypted), we will notify you promptly with the following information:

- A brief description of what happened;
- A description of the health information that was involved;
- Recommended steps you can take to protect yourself from harm;
- What steps we are taking in response to the breach; and,
- Contact procedures so you can obtain further information.

8. Right to Opt-Out of Fundraising Communications
As a non-profit organization, APHCV often relies on the generosity of donations from patients and others to continue to fulfill our mission which is to serve underserved individuals in our community. We may use or disclose the following limited patient health information to conduct fundraising activities without a patient's written authorization.

- Patient demographic data (patient name, address or other contact information, age/gender)
- Health insurance status
- Dates of patient health care services
- Treating physician information

If we conduct fundraising and we use communications like the U.S. Postal Service or electronic email for fundraising, you have the right to opt-out of receiving such communications from us.
Please contact our Privacy Officer (Mika Aoki) or Junior Privacy Officer (Jeff Wongsiriyanon) to opt-out of fundraising communications by writing us a letter and stating the reason if you choose to do so.

YOU MAY FILE A COMPLAINT ABOUT OUR PRIVACY PRACTICES

If you believe that your privacy rights have been violated or if you are dissatisfied with our privacy policies or procedures, you may file a written complaint either with us or with the federal government.

We will not take any action against you or change our treatment of you in any way if you file a complaint.

To file a written complaint with us, you may bring your complaint directly to our Privacy Officer (Mika Aoki) or Junior Privacy Officer (Jeff Wongsiriyanon), or you may mail it to the following address:

Asian Pacific Health Care Venture, Inc.
Administrative Office
4216 Fountain Avenue
Los Angeles, CA 90029

To file a written complaint with the federal government, please use the following contact information:

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20201

Toll-Free Phone: 1-(877) 696-6775

Website: http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html

Email: OCRComplaint@hhs.gov