# PATIENT INFORMATION SHEET - MINOR

PATIENT'S NAME: LAST | FIRST | MIDDLE INITIAL | DATE OF BIRTH:

HOME ADDRESS:

CITY: | STATE: | ZIP CODE:

HOME PHONE: ( ) | SEX: ☐ M ☐ F

FATHER'S NAME: | DATE OF BIRTH:

EMPLOYER: | OCCUPATION: | BUS. PHONE: ( )

MOTHER'S NAME: | DATE OF BIRTH:

EMPLOYER: | OCCUPATION: | BUS. PHONE: ( )

CHILDREN LIVING AT HOME (NAMES & BIRTH DATES)

NAME OF PERSON NOT LIVING WITH PATIENT TO CONTACT FOR EMERGENCY: | PHONE: ( )

## INSURANCE

PRIMARY INSURANCE CARRIER NAME: | POLICY ID #: | GROUP #:

INSURED'S NAME: LAST | FIRST | MIDDLE INITIAL

EMPLOYER: | PATIENT RELATIONSHIP TO INSURED: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER

SOCIAL SECURITY # OF INSURED:

SECONDARY INSURANCE CARRIER NAME: | POLICY ID #: | GROUP #:

INSURED'S NAME: LAST | FIRST | MIDDLE INITIAL

EMPLOYER: | RELATIONSHIP TO INSURED: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER

SOCIAL SECURITY # OR INSURED:

### PATIENT ELIGIBILITY WAIVER

I HEREBY ATTEST THAT I AM ELIGIBLE MEMBER OF THE HEALTH PLAN NOTED ABOVE. I AGREE THAT SHOULD IT BE DETERMINED THAT I AM INELIGIBLE FOR SERVICES RENDERED BY CATOU L. GREENBERG, M.D. OR BY ANOTHER FACILITY OR PHYSICIAN AS THE RESULT OF CATOU L. GREENBERG, M.D. PRIMARY CARE DIRECT REFERRAL, I WILL BE RESPONSIBLE FOR PAYMENT TO CATOU L. GREENBERG, M.D. OR IT'S AGENT FOR THESE SERVICES DEEMED INELIGIBLE OR NOT COVERED.

I AUTHORIZE THE RELEASE OF INFORMATION TO MY INSURANCE COMPANIES.

I AUTHORIZE PAYMENT DIRECTLY TO MY PHYSICIAN. I AUTHORIZE THIS PRACTICE TO ACT AS MY AGENT TO HELP ME TO SECURE PAYMENT FROM MY INSURANCE COMPANIES.

### TO WHOM IT MAY CONCERN:

I give permission for the physicians at Pacific Family Medicine to provide any necessary medical care to my monor child whose name is:

This authorization expires upon the minor's 18th birthday.

Signature

Print Name

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 changes whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to ensure this payment.

IN ORDER TO CONTROL COSTS OF BILLING WE REQUEST CHARGES FOR OFFICE VISITS AND/OR CO-PAYMENTS BE PAID AT THE CONCLUSION OF EACH VISIT.

SIGNED: | Print Form | DATE:

Pacific Family Medicine

# Confidential Patient History - Pediatric

**Name** ______________________________________________

**Date of Birth** _______________________

## Past Medical History

Has your child ever had any major medical problems? If so, please describe:

Has your child ever had any surgeries? Please list, including dates:

Any Major Accidents or injuries? ______________________________________________

Has your child ever been hospitalized any time other than the above, or at birth? Please list including dates:

Were there any problems with this child during pregnancy or at birth?

Was the child born vaginally, or by cesarean section? If cesarean please explain why:

What medications is your child currently taking? Please list dosages if possible, and any over-the-counter remedies, vitamins or herbs.

Has your child ever had any negative reactions to medication? Please explain:

Do any blood relatives have any major medical problems? If so, please list:

Was your child breast fed?________ For how long? ________________________

Are your child's immunizations up to date? Please bring copy of vaccination records for our chart if possible.

______________________________________________________________________________

Does your child smoke or exposed to smokers? ______________________

Has your child ever abused drugs or alcohol? ______________________

What are your child's hobbies or interests? ______________________

Does your child have a religious or spiritual support system or community in his/her life?

Do you have pets? ______________________

How often does your child exercise and what type of exercise does he/she do?

Does the child sleep well? ______________________

Would you say this child has a healthy, well rounded diet? ______________________

What do you consider to be major events that have happened in this child's life, i.e. Divorce, serious accident, death of a loved one, lottery win, trips around the world, etc?

Is there anything in particular that you think your doctor should know or that you would like to discuss with the doctor today? ______________________

## For Female Patients Only – please answer where applicable

How old were you when you had your first period? ______________________

Do you have irregular or painful periods? ______________________

When was your last menstrual period? ______________________

When was your last pap smear? ______________________

When was your last clinical breast exam? ______________________

Do you do a self breast exam monthly? ______________________

Do you use Birth control? ______________________

## For Male Patients Only

Do you do a monthly testicular self-exam? ______________________

| **Name of person completing this form** | **Signature** | **Date** |
|---|---|---|

Print Form

**In an effort to reduce contact we are asking you send records to us via email. You can email all records to ROIRequests@4securemail.com. Thank you**

# Medical Release Form

**To:**_______________________________________________________________
(Physician/ Medical Group)

**Address**:_______________________________________________________________

**City:**_____________________**State:**__________**Zip:** _____________________

**PH**:_ ______________________________**FAX:**_____________________________

**PLEASE RELEASE RECORDS AS FOLLOWS:**

**Last 5 years - chart notes, consult notes, labs, x-rays and special tests**
**& most recent Colonoscopy, Mammogram, PAP & Immunizations**

_______________________________________________________________

**Other:** _______________________________________________________________

## TO: Pacific Family Medicine

**Catou Greenberg MD**
**Karen Kim DO**
**Carol Shi MD**

**1441 Avocado Ave Ste 503**
**Newport Beach, CA. 92660**
**Ph: (949) 718-9020**
**Fax: (949) 718-9040**
**EMAIL RECORDS TO ROIREQUESTS@4SECUREMAIL.COM**

**Patient's Name**:______________________________**Date Of Birth**_______/_____/____

**Signature:**____________________________________**Date:**_______/_____/__________

**Relationship To Patient**:_________________________________________

# Patient Consent for Use and Disclosure of Protected Health Information

I hearby give my consent for the office of **Pacific Family Medicine** to disclose protected health information (PHI) about me to carry out treatment, payment and health operations (TPO). The Notice of Privacy Practices (NPP) provided by the office of Pacific Family Medicine (Catou Greenberg, M.D. Inc & Affiliated Providers) describes such uses and disclosures more completely.

I have the right to review the Notice of Privacy Practices prior to signing this consent from. The office of **Pacific Family Medicine** reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Scott Elliston, privacy officer.

With this consent, the office of **Pacific Family Medicine** may call my home or alternative location and leave messages on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to clinical care, including lab results, among others.

With this consent, the office of **Pacific Family Medicine** may mail to my home or alternative location any items that assist the practice of TPO, such as appointment reminder cards and patient statements as long as they are marked “Personal & Confidential”.

With this consent, the office of **Pacific Family Medicine** may email to my email address or other alternative location any items that assist the practice of carrying out the TPO, such as appointment reminder cards and patient statements. I have the right to request that the office of **Pacific Family Medicine** restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree with requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow the office of **Pacific Family Medicine** to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance to upon my prior consent. IF I do not sign, or later revoke it, the office o **Pacific Family Medicine** may decline to provide treatment to me.

_______________________________________ _______________________________________

Signature of Patient or Legal Guardian Print Name

_______________________________________ ____________________

Print Name of Legal Guardian Date

# Patient Partnership

Dear Patient,

Welcome to Pacific Family Medicine. We intend to provide you with the care and service you expect and deserve. Achieving your ***best possible health*** requires a "partnership" between you and your doctor. As our "partner in health" we ask you to help us in the following ways:

> **Schedule visits with my doctor for routine physical exams and other recommended health screenings.**
> I understand that my doctor will explain to me which regular health screening are appropriate for my age, gender and personal and family history. I understand I will need to complete these recommended health screenings (mammogram, immunizations, pap smears etc…)**These Health screenings are tests that can help detect life-threatening diseases and conditions.** If I visit my doctor only for treatment of immediate problems and forget to arrange for regular health screenings, I put myself at risk of letting serious health problems go undetected. I will schedule regular visits with my doctor to complete my physical exam and to discuss these health screenings.
>
> **Keep follow-up appointments and reschedule missed appointments.**
> I understand that my doctor will want to know how my condition progresses after I leave the office. Returning to my doctor on time gives him or her the chance to check my condition and my response to treatment. During a follow up appointment, my doctor might order tests, refer me to a specialist, prescribe medication, or even discover and treat a serious health condition. If I miss an appointment and don't reschedule, I run the risk that my physician will not be able to detect and treat a serious health problem. I will make every effort to reschedule messed appointments as soon as possible.
>
> **Call the office when I do not hear the results of lab tests and other tests.**
> I understand that my physician's goal is to report my lab and test results to me as soon as possible. However, if I do not hear from my physician's office within the time specified, I will call the office for my test results.
>
> **Inform my Doctor if I decide not to follow his or her recommended treatment plan.**
> I understand that after examining me, my doctor may make certain recommendations based on what he or she feels is best for my health. This might even include prescribing medication, referring me to a specialist, ordering labs and tests, or even asking me to return to the office within a certain period of time. I understand that not following my treatment plan can have serious negative effects on my health. I will let my doctor know whenever I decide not to follow his or her recommendations so that he or she may fully inform me of any risks associated with my decision to delay or refuse treatment.

Thank you for your partnership. As our patient, you have the right to be informed about your health care. We invite you, at anytime, to ask questions, report symptoms, or discuss any concerns you may have. If you need more information about your health or condition, please ask.

__________________________________ _________ __________________________________

Patient Signature | Date | Physician Signature

# Pacific Family Medicine

# Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information, especially as we introduce technology in the form of electronic health records and related interoperability to increase the timeliness and efficiency of your medical care.

- 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

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

This medical practice collects health information about you and stores it in an electronic health record. 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:

A1. 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, often in an electronic format, with other physicians or other health care providers who will provide services to you 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.

A2. 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 disclose information to our billing service and to other health care providers to assist in obtaining payment for services they have provided to you.

A3. 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. 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 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 of your medical information. Although federal law does not protect health information which is disclosed to someone other than another healthcare provider, health plan or healthcare clearinghouse, under California law all recipients of health care information are prohibited from re-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 efforts to improve health or reduce health care costs, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, or their health care fraud and abuse detection and compliance efforts. We may also share medical information about you to all the other health care providers and health plans who participate in any managed health care operations affiliated with this medical practice.

A4. 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.

A5. 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. Others who sign in may see your name.

A6. 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 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 communicating with your family and others.

A7. Marketing. We may contact you to give you information about products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments or health-related benefits and services that may be of interest to you. This may include promotional items with a small value. We may also encourage you to purchase a product or service when we see you. We will not use or disclose your medical information without your written authorization.

A8. 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 minimum 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.

A9. 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.

A10. 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.

A11. 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.

A12. 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 or locating a suspect,

fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.

A13. Coroners. We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.

A14. Organ or tissue donation. We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.

A15. 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.

A16. 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.

A17. 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.

A18. 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.

# 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 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 at any time by written request.

# C. Your Health Information Rights

C1. 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. We reserve the right to accept or reject your request, and will notify you of our decision.

C2. 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. We will attempt to comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications. However, we utilize a variety of automated systems which may restrict our ability to comply with certain requests. For example, patient statements from our automated billing system will always be sent to your home address.

C3. Right to Inspect and Copy. You have the right to inspect and have a 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 and whether you want to inspect it or get a copy of it. We will charge a reasonable fee, as allowed by California law. We may deny your request under limited circumstances. If we deny your request to access your child's records because we believe allowing access would be reasonably likely to cause substantial harm to your child, 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.

C4. 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. You also have the right to request that we add to your record a statement of up to 250 words concerning any statement or item you believe to be incomplete or incorrect.

C5. 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 A1 (treatment), A2 (payment), A3 (health care operations), A6 (notification and communication with family) and A16 (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.

C6. You have a right to a paper copy of this Notice of Privacy Practices. 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 bottom of this Notice of Privacy Practices.

# D. Changes to this Notice of Privacy Practices

We reserve the right to amend 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, and will offer you a copy 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 below. If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to the Department of Health and Human Services (DHHS) in Washington DC. **You will not be penalized for filing a complaint.**

Privacy Officer: Linda McCarthy - (949) 718-9020
Effective Date: June 1, 2010

# Communicating with You

To effectively communicate with you about your medical information we request that you complete this form identifying the best ways to provide you with your confidential information. We may need to communicate test results, prescription information or respond to a message you left for your physician's office. **We may communicate with you through mail, secure email (NextMD Patient Portal), and telephone, including leaving messages on your answering machine's/voice mail.**

Please check all boxes that give Family Care Centers permission to use for your communications:

❑ You may contact me by telephone *Phone Number: ______________ ❑ Message OK ❑ Cell ❑ Home ❑ Work

*Phone Number: ______________ ❑ Message OK ❑ Cell ❑ Home ❑ Work

*Phone Number: ______________ ❑ Message OK ❑ Cell ❑ Home ❑ Work

**Please list any persons you would like to have access to your billing, appointment or health information, such as your spouse, caretaker or other family member. We will ask for additional consent prior to releasing information related to Behavior Health and/or HIV test results.**

| Name/Phone Number | Relationship | Options |
|---|---|---|
| 1. | | ❑ Billing Information<br>❑ Appointment Information<br>❑ Medical/Health Information |
| 2. | | ❑ Billing Information<br>❑ Appointment Information<br>❑ Medical/Health Information |

This request supersedes any prior request for communication of information I may have made.

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# Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge that I received a copy of the notice of Privacy Practices for the above medical practice. I further acknowledge that a copy of the current notice is posted in the reception area and that any amended notice of Privacy Practices will be made available at my next appointment.

If <u>not</u> signed by the patient, please indicate:

Relationship:

- o Parent or guardian of minor patient
- o Legal Guardian or conservator of an incapacitated patient
- o Beneficiary or personal representative of deceased patient

Name of Patient, if patient **NOT** signing: ______________________

______________________ ______________ ______________

Signature of Patient/Responsible Party Patient Date of Birth Todays Date

______________________ ______________________

Name of Patient/Responsible Party (Print) Relationship to Patient

# Patients Bill Of Rights

*Every person who enters Pacific Family Medicine for care has rights. A copy of these rights will be provided to each patient at the time of registration. If necessary, interpretation services will be provided to the patient to assist in communication of these rights.*

*While you are a patient at Pacific Family Medicine you have the right to:*

1. Exercise these rights without regard to sex, economic status, educational background, race, color, religion, ancestry, national origin, sexual orientation or marital status, or the source of payment for care.
2. Be informed of your rights, in advance of providing or discontinuing care, whenever possible.
3. Know the name of the physician who has primary responsibility for coordinating the care and the names and professional relationships of other physicians and non-physicians who will see the patient.
4. Have a family member or representative and your own physician notified promptly of your status.
5. Considerate and respectful care that safeguards cultural, psychosocial and spiritual values.
6. Receive care in a safe setting.
7. Be free from all forms of abuse or harassment.
8. Receive information about your health status, course of treatment, prospects for recovery and outcomes of care (including unanticipated outcomes) in terms you can understand. Participate actively in decisions regarding medical care including development and implementation of your care plan and to the extent permitted by the law. This includes the right to refuse treatment.
9. Receive as much information about any proposed treatment or procedure as you may need in order to give informed consent or to refuse this course of treatment. Except in emergencies, this information shall include a description of the procedure or treatment, the medically significant risks involved in this treatment, the likelihood of achieving the desired results, alternate courses of treatment or non-treatment and the risks involved in each and to know the name of the person who will carry out the procedure or treatment.
10. Formulate advance directives and have staff and practitioners who provide care comply with these directives or be informed if Family Care Centers is unable to honor your advance directive wishes.
11. Identify a surrogate decision maker who can make health care decisions for you if you are unable and have all the patients' rights apply to the this person or others who may have legal responsibility to make decisions regarding medical care on your behalf.
12. Personal privacy.
13. Full consideration of privacy concerning the medical care program. Case discussion, consultation, examination and treatment are confidential and should be conducted discreetly. You have the right to be advised as to the reason for the presence of any individual.
14. Confidential treatment of all communication, recordings/films and records pertaining to the care and the stay in the hospital. Written permission shall be obtained before the medical records and/or films can be made available to anyone not directly related with the care.
15. Access information contained in your medical record within a reasonable time frame.
16. Request an amendment to and receive an accounting of disclosures regarding your health information.
17. Be free from restraints of any form used as a means of coercion, discipline, convenience or retaliation by staff.
18. Reasonable responses to any reasonable requests made for service.
19. Reasonable continuity of care and to know in advance the time and location of appointment as well as the identity of persons providing the care.
20. Examine and receive an explanation of the all charges regardless of source of payment.
21. Know which Family Care Centers rules and policies apply to your conduct while a patient.
22. Designate visitors of your choosing, if you have decision making capacity, whether or not the visitor is related by blood or marriage, unless:

- No visitors are allowed
- The facility reasonably determines that the presence of a particular visitor would endanger the health or safety of a patient, a member of the health facility staff, or other visitor to the health facility, or would significantly disrupt the operations of the facility.
- You have indicated to the health facility staff that you no longer want this person to visits.
- To have your wishes considered for purposes of determining who may visit if you lack decision-making capacity and to have the method of that consideration disclosed in the hospital on visitation. At a minimum, Family Care Centers shall include any persons living in the household.

These sections may not be construed to prohibit a health facility from otherwise establishing reasonable restrictions upon visitation, including restriction upon the hours of visitation and number of visitors.

23. Request a list of and assistance with accessing protective or advocacy services in the community.
24. Appropriate assessment and management of pain.
25. If you suffer from severe chronic intractable pain, you have the option to request or reject the use of any or all modalities to relieve your pain, including opiate medication. Your doctor may refuse to prescribe you opiate medication, but if so, must inform you that there are physicians who specialize in the treatment of several chronic intractable pains with methods that include the use of opiates.
26. Be informed of any continuing health care requirements following discharge from Family Care Centers. Be informed that, with your authorization, Family Care Centers may provide a friend or family member with information about your continuing health care requirements.
27. Have complaints/concerns voiced by you or your representative addressed in a respectful manner, as soon as possible.
28. File a grievance. If you want to file a grievance with Family Care Centers, you may do so by writing or by calling.

Grievance Department/Patient Account Services
P.O. Box 16028
Newport Beach, CA 92659
Phone 657-241-3600 Fax 657-241-7706

Department of Health Services
Licensing and Certification
3901 Lennane Drive,
Suite 210
Sacramento, CA 95834
(916) 263-5800 or (800)-554-0354