NEW OFFICE POLICY!

In an effort to improve your access to timely care and comply with new Federal guidelines, patient communications regarding your personal health, appointment reminders, and practice updates will be delivered via e-mail and the secure online patient portal, Hello Health Portal Connect.

The patient portal can be accessed through our practice website drreddyforlife.com All patients

are asked to provide current email addresses and phone numbers.

Benefits of Portal Connect-

- **There is a no fee for this service. Dr Reddy has arranged for her patients to receive this service at no cost to the patient**
- **You can schedule appointments from any location for certain time slots**
- **You can access, organize, download your labs, test results**
- **You can communicate with the staff or Dr via HIPPA secure email**
- **You can share your results with your other Physicians**
- **You will find that the convenience and time savings are well worth it.**
- **We encourage you to take full advantage of all it has to offer.**

We want to reassure you that with Portal Connect, all of your medical information is protected and completely secure, much like your financial information is protected through online banking.

For technical assistance contact the Portal Connect team

Send an email: **info@portalconnect.net**

Call at: 1-866-779-1526

Pacific Coast Medical Group

Dr. Reddy and Staff welcome you!

Contact Information

11180 Warner Ave Suite 353 Fountain Valley, CA 92708

Phone: (714)968-6789 Fax: (714) 202-2626

Office Hours

Monday - Wednesday 9:00 am – 5:00pm (closed for lunch between 12:30 and 1:30) Thursday 9:00 am – 6:00 pm (closed for lunch between 12:00 and 1:00)

Friday – Closed

Medical Staff

Dr. Reddy – Medical Director

Administrator- Nicole

Casie - Nurse Practitioner

DJ- Nurse Practitionser

Sonny- Medical Assistant

Marissa- Receptionist

Indi- New Patient Asst

Auth-Chellie

Barbara-TrialCoordinator

PACIFIC COAST
MEDICAL GROUP

Patient Responsibilities

As an involved partner in my health care, I have the following responsibilities:

1) I will provide accurate health information to the doctor and staff and update my record with any changes.
2) I will schedule and attend **routine physical exams**, **follow up appointments**, **lab appointments**, **health maintenance exams** (pap smear, colonoscopy, mammogram, etc.), **referral appointments**, and **other diagnostic testing**. I put myself at risk by not detecting other medical diseases/diagnoses if I only see my doctor for immediate problems.
3) I will follow treatment plans recommended to me by my physician or other practitioner, including completing testing, making appointments with specialists, and taking my **medication as prescribed.** I will be sure to voice questions or concerns about my treatment plan during my appointments. I understand that not following my treatment plans may put my health at risk.
4) I will keep my appointments or cancel/reschedule them at least 24 hours before the scheduled appointment time. If I do not cancel or reschedule my appointment according to this time frame, I agree to pay the $50 cancellation fee. I understand that my doctor has me schedule these appointments to follow up on response to my treatment and to monitor my medical conditions. During these appointments my doctor may order tests, refer me to a specialist, change my medications, and diagnose medical problems. If I do not follow up I put my health at risk and may have medical conditions go undetected.
5) I will treat all providers and staff with respect and courtesy at all times.
6) I will fulfill my financial obligations for care provided to me at the time of my visit.
7) I will take charge of my health and make positive choices for my health.
8) I will take responsibility to understand my Health Insurance Plan and be aware of benefits, deductibles, and Health Plan limitations/exclusions. I will contact my Insurance carrier if I have any questions regarding my health coverage or pharmacy benefits.
9) I will take responsibility to have medication refill requests submitted in a timely fashion prior to being out of my medication. I also understand that medication refills may take up to 3-4 days to be processed or longer if the medication is not on my insurance formulary of covered medications.

I have read, understand, and agree to follow the above listed Patient Responsibility Policies to the best of my abilities.

PRINT NAME:	
DATE:	
SIGNATURE:	

PACIFIC COAST MEDICAL GROUP
LALLA-REDDY MEDICAL CORPORATION
REGISTRATION FORM

Today's date:	PCP:

PATIENT INFORMATION- THIS MUST BE COMPLETED IN FULL PRIOR TO OFFICE VISIT

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name?	If not, what is your legal name?	(Former name):	Birth date:	Age:	Sex:
❑ Yes ❑ No			/ /		❑ M ❑ F

Street address:	Social Security no.:	Home phone no.:
		( )

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.:
		( )

Chose clinic because/Referred to clinic by (please check one box):	❑ Dr. _____	❑ Insurance	❑ Hospital

❑ Family	❑ Friend	❑ Close to home/work	❑ Yellow Pages	❑ Other

Other family members seen here:	

E-MAIL:

INSURANCE INFORMATION

Please give your INSURANCE CARD AND DRIVERS LICENSE OR ID to the receptionist, PRIOR TO VISIT

Person responsible for bill:	Birth date:	Address (if different):	Home phone no.:
	/ /		( )

Is this person a patient here?	❑ Yes	❑ No

Occupation:	Employer:	Employer address:	Employer phone no.:
			( )

Is this patient covered by insurance?	❑ Yes	❑ No	If no, Explain:

Please indicate primary insurance	❑ BLUE SHIELD	❑ AETNA	❑ CIGNA	❑ HEALTHNET	❑ ADOC

❑ MEDICARE	❑ BLUE CROSS	❑ CALOPTIMA	❑ MEDICAL/_____	❑ MONARCH	❑OTHER_____

Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Group no.:	Policy no.:	Co-payment:
		/ /			$

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

IN CASE OF EMERGENCY- THIS INFORMATION IS REQUIRED FOR ALL PATIENTS

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Work phone no.:
		( )	( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize LALLA-REDDY MED CORP or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

PACIFIC COAST MEDICAL GROUP
11180 Warner Ave Suite 353
FOUNTAIN VALLEY, CA 92708
714-968-6789

NEW PATIENT HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name *(Last, First, M.I.):*	☐ M ☐ F	**DOB:**	
Marital status:	☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Gay ☐ Bisexual ☐ Transgender		
Previous or referring doctor:		**Date of last physical exam:**	

PERSONAL HEALTH HISTORY

Childhood illness:	☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio ☐Hepatitis	
Immunizations and dates:	☐ Tetanus	☐ Pneumovax
	☐ Hepatitis A/B/C	☐ Varicella
	☐ Flu vaccine	☐ MMR *Measles, Mumps, Rubella*

List any medical problems that other Physicians have diagnosed:

1	5
2	6
3	7
4	8

Surgeries:

Year	Reason	Hospital

Other Hospitalizations:

Year	Reason	Hospital

Have you ever had a blood transfusion? Why?	☐ Yes	☐ No

PLEASE GO TO PAGE 2

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Name the Drug	**Strength**	**Frequency Taken**

Allergies to medications	
Name the Drug	**Reaction You Had**

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE WILL BE KEPT STRICTLY CONFIDENTIAL.

Exercise	☐ Sedentary (No exercise)					
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)					
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)					
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)					
Diet	Are you dieting?				☐ Yes	☐ No
	If yes, are you on a physician prescribed medical diet?				☐ Yes	☐ No
	# Of meals you eat in an average day?					
	Rank salt intake	☐ Hi	☐ Mod	☐ Low		
	Rank fat intake	☐ Hi	☐ Mod	☐ Low		
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Regular Soda	☐ Diet Soda	
	# Of cups/cans per day?					
Alcohol	Do you drink alcohol?				☐ Yes	☐ No
	If yes, what kind?					
	How many drinks per week? 1 2 3 4 5 >6		How many drinks per day? 1 2 3 4 5 >6			
	Are you concerned about the amount you drink?				☐ Yes	☐ No
	Have you considered stopping?				☐ Yes	☐ No
	Have you ever experienced blackouts?				☐ Yes	☐ No
	Are you prone to "binge" drinking?				☐ Yes	☐ No
	Do you drive after drinking?				☐ Yes	☐ No
Tobacco	Do you use tobacco? # of years?_____ When did you quit?				☐ Yes	☐ No
	☐ Cigarettes –_____ pks./day	☐ Chew - _____ #/day	☐ Cigars _____ #/day	☐ Marijuana		
Drugs	Do you currently use recreational or street drugs? Crystal methemphetamines? Other?				☐ Yes	☐ No
	Have you in the past? If so when did you last use?				☐ Yes	☐ No
	Have you ever gone through Rehab? Yes or No If yes. When? Describe					
	Have you ever given yourself street drugs with a needle? (Intravenous Drug Abuse)				☐ Yes	☐ No

PLEASE GO TO PAGE 3

Sex	**Are you sexually active?**	☐ Yes	☐ No
	Do you practice safe sex? Please Circle- Sometimes Always Never Other:_____		
	Have you ever been treated for an STD? (syphilis/herpes/gonorrhea/genital warts/chlamydia) Circle the STD's you have had and describe treatment.	☐ Yes	☐ No
	If you are not trying to get pregnant, Please list contraceptive or barrier method used:		
	Sexual Preference ☐ Gay ☐ Lesbian ☐ Straight ☐ Bisexual ☐ Transgender	☐ Yes	☐ No
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?	☐ Yes	☐ No
Personal Safety	**Do you live alone?**	☐ Yes	☐ No
	Do you have frequent falls?	☐ Yes	☐ No
	Do you have vision or hearing loss?	☐ Yes	☐ No
	Do you have an Advance Directive or Living Will?	☐ Yes	☐ No
	Would you like information on the preparation of these documents?	☐ Yes	☐ No
	Physical and/or mental abuse has also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?	☐ Yes	☐ No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** *Maternal*		
	☐ M ☐ F		**Grandfather** *Maternal*		
	☐ M ☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F		**Grandfather** *Paternal*		

MENTAL HEALTH

Is stress a major problem for you? If yes, how do you normally calm yourself down?	☐ Yes	☐ No
Do you feel depressed? Do you cry frequently?	☐ Yes	☐ No
Do you panic when stressed?	☐ Yes	☐ No
Do you have problems with eating or your appetite?	☐ Yes	☐ No
Have you ever been diagnosed anorexic or bulimic?	☐ Yes	☐ No
Have you ever attempted suicide? If yes. Please describe.	☐ Yes	☐ No
Have you ever seriously thought about hurting yourself?	☐ Yes	☐ No
Do you have trouble sleeping?	☐ Yes	☐ No
Have you ever been to a counselor or psychiatrist? Are you seeing one presently? Yes or No	☐ Yes	☐ No
Have you ever been admitted into a Psychiatric Facility?	☐ Yes	☐ No

PLEASE GO TO PAGE 4

WOMEN ONLY

Age at onset of menstruation: Date of last menstrual period:_____		
Heavy periods, irregularity, spotting, pain, or discharge?	☐ Yes	☐ No
Number of pregnancies _____ Number of live births _____		
Are you pregnant or breastfeeding?	☐ Yes	☐ No
Have you had a D&C, hysterectomy, or Cesarean?	☐ Yes	☐ No
Any urinary tract, bladder, or kidney infections within the last year?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Any problems with control of urination?	☐ Yes	☐ No
Any hot flashes or sweating at night?	☐ Yes	☐ No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	☐ Yes	☐ No
Have you experienced any recent breast tenderness, lumps, or nipple discharge?	☐ Yes	☐ No
Have you ever had anal Intercourse?	☐ Yes	☐ No
Date of last pap and rectal exam? Pap exam_____/_____/_____ Rectal Exam _____/_____/_____		

MEN ONLY

Do you usually get up to urinate during the night?	☐ Yes	☐ No
If yes, # of times _____		
Do you feel pain or burning with urination?	☐ Yes	☐ No
Have you ever noticed blood in your urine?	☐ Yes	☐ No
Do you feel a burning discharge from your penis?	☐ Yes	☐ No
Has the force of your urination decreased? When did you notice this?	☐ Yes	☐ No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	☐ Yes	☐ No
Do you have any problems emptying your bladder completely?	☐ Yes	☐ No
Do you have difficulty maintaining or achieving an erection or have concerns re: ejaculation?	☐ Yes	☐ No
Describe difficulty with erection/ejaculation and have you tried treatment?	☐ Yes	☐ No
Any testicular pain or swelling?	☐ Yes	☐ No
Date of last prostate and rectal exam? Prostate ___/_____/_____ Rectal _____/_____/_____	☐ Yes	☐ No
Have you ever had anal intercourse? Yes or no If yes, is this a regular practice?	☐ Yes	☐ No
Are you a top/bottom or versatile? (Circle choice)		
Have you ever had anal or penile warts?	☐ Yes	☐ No
If yes, have you ever been treated? Yes or No How were you treated?		

OTHER PROBLEMS

Check if you have, or have had any symptoms in the following areas to a significant degree and briefly explain.

☐ Skin	☐ Chest/Heart	☐ Recent changes in:
☐ Head/Neck	☐ Back	☐ Weight
☐ Ears	☐ Intestinal	☐ Energy level
☐ Nose	☐ Bladder	☐ Ability to sleep
☐ Throat	☐ Bowel	☐ Other pain/discomfort:
☐ Lungs	☐ Circulation	

HIV DIAGNOSIS, HISTORY AND MEDICATION REVIEW:

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name *(Last, First, M.I.):* ☐ M ☐ F	**DOB:**
DATE OF HIV DIAGNOSIS: **LAST CD4 COUNT:**	**LAST VIRAL LOAD:**
HAVE YOU EVER HAD A PHENOTYPE/GENOTYPE TEST? YES OR NO	**WHEN?**
Previous or referring doctor:	**Date of last physical exam:**

PERSONAL HEALTH HISTORY

List any Opportunistic Infections related to HIV; that other MDs have diagnosed:

1	5
2	6
3	7
4	8

List ALL Antiretroviral (HIV) drugs you have taken in the past:

Name the Drug	Strength	Frequency Taken

List ALL Antiretroviral (HIV) drugs that you stopped and explain why:

Name the Drug	Reaction You Had or why your Doctor or you stopped the drug

PACIFIC COAST MEDICAL GROUP

Sujata (Sue) Lalla-Reddy MD

11180 Warner Ave Suite 353
FOUNTAIN VALLEY, CA 92708
Phone: 714-968-6789 Fax 714-202-2626

AUTHORIZATION TO RELEASE MENTAL HEALTH, VARIOUS ADDICTIONS OR HIV HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous MD Name: _____ Social Security #: _____

I request and authorize to release healthcare information of the patient named above to:

Name: _____

Address: _____

City: _____

State: _____

Zip Code: _____

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates:

☐ All healthcare information

☐ Other: _____

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea. (NOT INCLUSIVE)

☐ Yes ☐ No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: _____ Date Signed: _____

THIS AUTHORIZATION EXPIRES ONE YEAR AFTER IT IS SIGNED.

LALLA-REDDY MED. CORPORATION

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

Physician Orders for Life-Sustaining Treatment (POLST)

EMSA #111 B
(Effective 4/1/2011)

First follow these orders, then contact physician. This is a Physician Order Sheet based on the person's current medical condition and wishes. Any section not completed implies full treatment for that section. A copy of the signed POLST form is legal and valid. POLST complements an Advance Directive and is not intended to replace that document. Everyone shall be treated with dignity and respect.

Patient Last Name:	Date Form Prepared:
Patient First Name:	Patient Date of Birth:
Patient Middle Name:	Medical Record #: *(optional)*

A — CARDIOPULMONARY RESUSCITATION (CPR): *If person has no pulse and is not breathing. When NOT in cardiopulmonary arrest, follow orders in Sections B and C.*

Check One

☐ **Attempt Resuscitation/CPR** (Selecting CPR in Section A **requires** selecting Full Treatment in Section B)

☐ **Do Not Attempt Resuscitation/DNR** (**A**llow **N**atural **D**eath)

B — MEDICAL INTERVENTIONS: *If person has pulse and/or is breathing.*

Check One

☐ **Comfort Measures Only** Relieve pain and suffering through the use of medication by any route, positioning, wound care and other measures. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. ***Transfer to hospital only*** *if comfort needs cannot be met in current location.*

☐ **Limited Additional Interventions** In addition to care described in Comfort Measures Only, use medical treatment, antibiotics, and IV fluids as indicated. Do not intubate. May use non-invasive positive airway pressure. Generally avoid intensive care.

☐ ***Transfer to hospital only*** *if comfort needs cannot be met in current location.*

☐ **Full Treatment** In addition to care described in Comfort Measures Only and Limited Additional Interventions, use intubation, advanced airway interventions, mechanical ventilation, and defibrillation/ cardioversion as indicated. ***Transfer to hospital*** *if indicated. Includes intensive care.*

Additional Orders: _____

_____

C — ARTIFICIALLY ADMINISTERED NUTRITION: *Offer food by mouth if feasible and desired.*

Check One

☐ No artificial means of nutrition, including feeding tubes.
☐ Trial period of artificial nutrition, including feeding tubes.
☐ Long-term artificial nutrition, including feeding tubes.

Additional Orders: _____
_____
_____

D — INFORMATION AND SIGNATURES:

Discussed with: ☐ Patient (Patient Has Capacity) ☐ Legally Recognized Decisionmaker

☐ Advance Directive dated _____ available and reviewed →
☐ Advance Directive not available
☐ No Advance Directive

Health Care Agent if named in Advance Directive:
Name: _____
Phone: _____

Signature of Physician

My signature below indicates to the best of my knowledge that these orders are consistent with the person's medical condition and preferences.

Print Physician Name:	Physician Phone Number:	Physician License Number:
Physician Signature: *(required)*		Date:

Signature of Patient or Legally Recognized Decisionmaker

By signing this form, the legally recognized decisionmaker acknowledges that this request regarding resuscitative measures is consistent with the known desires of, and with the best interest of, the individual who is the subject of the form.

Print Name:		Relationship: *(write self if patient)*
Signature: *(required)*		Date:
Address:	Daytime Phone Number:	Evening Phone Number:

SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

Patient Information

Name (last, first, middle):	Date of Birth:	Gender: M F

Health Care Provider Assisting with Form Preparation

Name:	Title:	Phone Number:

Additional Contact

Name:	Relationship to Patient:	Phone Number:

Directions for Health Care Provider

Completing POLST

- Completing a POLST form is voluntary. California law requires that a POLST form be followed by health care providers, and provides immunity to those who comply in good faith. In the hospital setting, a patient will be assessed by a physician who will issue appropriate orders.
- POLST does not replace the Advance Directive. When available, review the Advance Directive and POLST form to ensure consistency, and update forms appropriately to resolve any conflicts.
- POLST must be completed by a health care provider based on patient preferences and medical indications.
- A legally recognized decisionmaker may include a court-appointed conservator or guardian, agent designated in an Advance Directive, orally designated surrogate, spouse, registered domestic partner, parent of a minor, closest available relative, or person whom the patient's physician believes best knows what is in the patient's best interest and will make decisions in accordance with the patient's expressed wishes and values to the extent known.
- POLST must be signed by a physician and the patient or decisionmaker to be valid. Verbal orders are acceptable with follow-up signature by physician in accordance with facility/community policy.
- Certain medical conditions or treatments may prohibit a person from residing in a residential care facility for the elderly.
- If a translated form is used with patient or decisionmaker, attach it to the signed English POLST form.
- Use of original form is strongly encouraged. Photocopies and FAXes of signed POLST forms are legal and valid. A copy should be retained in patient's medical record, on Ultra Pink paper when possible.

Using POLST

- Any incomplete section of POLST implies full treatment for that section.

Section A:

- If found pulseless and not breathing, no defibrillator (including automated external defibrillators) or chest compressions should be used on a person who has chosen "Do Not Attempt Resuscitation."

Section B:

- When comfort cannot be achieved in the current setting, the person, including someone with "Comfort Measures Only," should be transferred to a setting able to provide comfort (e.g., treatment of a hip fracture).
- Non-invasive positive airway pressure includes continuous positive airway pressure (CPAP), bi-level positive airway pressure (BiPAP), and bag valve mask (BVM) assisted respirations.
- IV antibiotics and hydration generally are not "Comfort Measures."
- Treatment of dehydration prolongs life. If person desires IV fluids, indicate "Limited Interventions" or "Full Treatment."
- Depending on local EMS protocol, "Additional Orders" written in Section B may not be implemented by EMS personnel.

Reviewing POLST

It is recommended that POLST be reviewed periodically. Review is recommended when:

- The person is transferred from one care setting or care level to another, or
- There is a substantial change in the person's health status, or
- The person's treatment preferences change.

Modifying and Voiding POLST

- A patient with capacity can, at any time, request alternative treatment.
- A patient with capacity can, at any time, revoke a POLST by any means that indicates intent to revoke. It is recommended that revocation be documented by drawing a line through Sections A through D, writing "VOID" in large letters, and signing and dating this line.
- A legally recognized decisionmaker may request to modify the orders, in collaboration with the physician, based on the known desires of the individual or, if unknown, the individual's best interests.

This form is approved by the California Emergency Medical Services Authority in cooperation with the statewide POLST Task Force.
For more information or a copy of the form, visit **www.caPOLST.org**.

SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

YOUR HEALTH INFORMATION PRIVACY RIGHTS

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain privacy rights concerning your health care information. Under this law your health care provider generally cannot give your information to your employer, use or share your information for marketing or advertising purposes, or share private notes about your mental health counseling sessions without your written consent. As one of your health care providers it is our responsibility to keep your information safe and secure. We also need to make sure that your information is protected in a way that does not interfere with your health care. It is important that you understand that your information can be used and shared in the following ways:

- For your treatment and care coordination. Multiple health care providers may be involved in your treatment directly and indirectly.
- With your family, friends, relatives, or others that you identify who are involved in your health care or health care bills.
- To protect the public's health, such as reporting when the flu is in your area.
- To make required reports to the police, such as gunshot wounds.
- Obtain payment from third party payers.

In order to provide you with service that best meets your privacy needs, please tell us how best to contact you when needed. Please check all that apply:

___Please do not phone me at home. Use this alternate phone number: _____
___Please do not phone me at work. Use this alternate phone number: _____
___Please do not leave messages on my answering machine.
___Please do not contact me by email.
___Please send mail, including my bills, to this alternate address: _____
Other request (please describe): _____

Email Communication: Dr. Reddy and staff often utilize email to correspond with her clients and other physicians regarding her clients. However, such email correspondences are not secure. They could theoretically be intercepted, read and information could be misused. I understand that such communications are not secure and hereby release Dr. Reddy and staff from any responsibility or liability in connection with using unsecured email for communication. I understand that I can choose to use the portal for secure email correspondence.
Regardless, if at any time I email a question to Dr. Reddy and staff, I hereby authorize a reply via unsecured email and agree not to hold Dr. Reddy responsible for any interception or misuse of such information.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our Notice provides a description of the uses and disclosures we may make of your protected health information and of other important matters about your protected health information. A copy of our notice is available upon request. We encourage you to read it carefully before signing this consent. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain. You may obtain a copy of our Notice of Privacy Practices at any time by contacting:

Lalla Reddy Medical Corporation (714) 968-6789

I have had full opportunity to read and consider the contents of this consent form and Notice of Privacy Practices. I understand that by signing this consent form I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment and healthcare operations.

_____
Patient Name (Please Print. Include parent/guardian name if patient is a minor.)

_____ _____/_____/_____
Patient Signature Date