PLACER PRIVATE PHYSICIANS

Personalized family and sports medicine

Brön Hedman, MD
drhedman@placermd.com

Rich Lichti, MD
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Lezley Brown, MD
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drsivia@placermd.com

SERVICES AGREEMENT

Last Name: _____ First Name: _____ Date: _____

Address: _____ City, State, Zip: _____

Phone Numbers Home: _____ Mobile: _____

Email: _____

Social Security Number: _____ DOB: _____

If spouse or another adult is also joining with the above primary patient, please provide:

Last Name: _____ First Name: _____

Address: _____ City, State, Zip: _____

Phone Numbers Home: _____ Mobile: _____

Email: _____

Social Security Number: _____ DOB: _____

If other non-adult family members are joining the practice as well, please add the following information below:

Child: _____SS#_____DOB_____

Child: _____SS#_____DOB_____

Child: _____SS#_____DOB_____

Child: _____SS#_____DOB_____

PLACER PRIVATE PHYSICIANS
PRIVATE PRACTICE PATIENT AGREEMENT

This Private Practice-Patient Agreement ("Agreement") specifies the terms and conditions under which, you, the undersigned patient ("Patient") may voluntarily elect to participate in the healthcare services defined below offered by Placer Private Physicians, Inc., a California professional corporation ("Practice"), with such services further described in Schedule A and as follows:

- Practice's comprehensive integrative medicine diagnostic routine exam services, provided regardless of medical condition or necessity, supported by follow-up routine diagnostic exams as further specified in Schedule A (collectively "Wellness Exams"); and

- An online health data storage and communication facilitation platform plan designed to provide efficient and reliable electronic communication and health data storage support for Wellness Exams and to help Patient to achieve Wellness Exams-based health goals ("Health Data Plan"). Wellness Exams and the Health Data Plan described in Schedule A are collectively the "Wellness Exam Services" and Patient and Practice are referred to individually as "Party" or collectively as the "Parties."

WELLNESS EXAM SERVICES

Practice makes Wellness Exam Services available to Patient in exchange for Patient's payment of the program subscription fees outlined in Schedule A ("Services Fees"). Services Fees may increase from time to time with Patient's voluntary consent in advance but will apply to renewal terms. If Services Fees increase, Practice will notify Payment in writing with the option to consent to the increase.

Practice reserves the right to update the Wellness Exam Services in Schedule A from time to time, and if it does, Practice will notify Patient of any changes within thirty (30) days after a change is made and shall secure Patient's voluntary consent to any such modification of Wellness Exam Services or Services Fees. Wellness Exam Services exceed or are beyond those covered by Patient's Medicare, Medicaid, or private insurance plan (collectively "Plan").

PAYMENT OPTIONS

Patient may pay the Services Fees with a check, credit card or cash/ACH. Please make checks payable to Placer Private Physicians, Inc. Wellness Exam Services costs are designed to qualify as eligible medical expenses such that Patient may pay Services Fees with health saving account ("HSA") funds or with flexible spending account ("FSA") fund or health reimbursement account ("HRA") funds, but this is not assured or promised. Patient must confirm eligibility with Patient's tax expert or FSA/HRA plan coordinator as Practice cannot guarantee medical expense eligibility due to variable factors applicable to each Patient. Services Fees cover the availability of the Wellness Exam Services selected by and subscribed to by Patient for a period of one (1) year. Patient must subscribe to Wellness Exam Services and pay Services Fees for an initial mandatory non-refundable minimum of three (3) months.

RENEWALS AND TERMINATION

This Agreement will automatically renew one (1) year from the date of this Agreement unless the Practice receives written notice from Patient to terminate this Agreement thirty (30) days before Patient's renewal date or Practice terminates the Agreement. Failure to pay the renewal Services Fees before the expiration of the prior period may result in termination of this Agreement. The Practice is permitted to terminate this Agreement with thirty (30) days' prior written notice to Patient, in which case Patient will receive a prorated refund of the Services Fees but the delivery of any Wellness Exams renders Services Fees substantially earned by Practice.

HEALTH CARE SERVICES EXCLUDED FROM SERVICES FEES

Services Fees cover only the availability of Wellness Exam Services subscribed to by Patient as described in this Agreement and Schedule A. If the Practice provides services other than the Wellness Exam Services described in this Agreement and listed in Schedule A, the Parties may agree upon any additional charges, if any, to the extent the Patient's Plan does not cover those services. Patient acknowledges that either Patient or Patient's Plan will be responsible for such additional charges for services outside of Wellness Exam Services. Any charges to Patient for any services outside of Plan coverage and Wellness Exam Services will be at Practice's usual, reasonable and customary rates with Patient's advance consent. Plan co-payments, deductibles, and the costs for all services other than Wellness Exam Services are the sole responsibility of the Patient.

ELECTRONIC COMMUNICATIONS

If Patient wishes to communicate through electronic mediums with the Practice, Patient needs to be aware that electronic mediums may not always constitute a secure method for sending or receiving sensitive personal health information. Practice will take reasonable steps to keep Patient's communications confidential and secure and comply with applicable health data privacy obligations under applicable laws. Please refer to Practice's separate Electronic Communications Agreement for further applicable details in this regard, which is integrated herein by this reference.

APPOINTMENTS AND SCHEDULING

Appointments with the Practice are scheduled through the Practice office to ensure ample time is given to each Patient. If Patient has an urgent concern, Patient shall call the Practice office and Patient will be given an appointment that will accommodate the urgency. Walk-ins are not conducive to the thoughtfully planned schedule, so we advise Patient to schedule appointments in advance.

MEDICARE/PRIVATE INSURANCE

If Patient is or becomes Medicare eligible, Patient acknowledges that Practice is a participating Medicare provider and Practice will submit reimbursement claims to Medicare for all Medicare-covered services Practice provides to Patient. Patient shall **not** submit to Medicare any claim for payment of Services Fees or request that Practice submit such a claim. Patient acknowledges and understands that Medicare does not cover and will not pay for the Wellness Exam Services, *and agrees **not** to submit Services Fees to Medicare for reimbursement.*

VACATIONS AND ILLNESS FOR PRACTICE HEALTHCARE PROFESSIONALS

Patient acknowledges that there may be times that Patient cannot contact a Practice healthcare professional due to vacations or illness, or due to technical defects with either Patient's or Practice's electronic communication equipment. Patient acknowledges that, should a Practice healthcare professional become unavailable, the Practice shall make every effort to give advance notice to Patient so that scheduled Wellness Exam Services can be scheduled on another date. In cases of emergency, please dial 9-1-1 and/or seek emergency/ER medical attention.

COMPLIANCE WITH LAW

In establishing the Wellness Exam Services programs, Practice intends to do so in compliance with all applicable laws. This Agreement shall be governed by and construed in accordance with the laws of the state in which Practice is licensed and practicing, without application of choice-of-law principles. If there is a change of any law, regulation or rule, federal, state or local, which affects the Agreement or the activities of either Party under the Agreement, or any change in judicial or administrative interpretation of any such law, regulation or rule, this Agreement shall be deemed modified so as to remain in compliance with such laws.

PRACTICE IS NOT AN INSURER

Practice is not an insurance company and is not promising or delivering unlimited care or services for the Services Fees. Practice presumes that Patient is either eligible for Medicare, or otherwise has a private or public Plan that provides health care coverage for healthcare services not covered by Services Fees.

AGREEMENT ASSIGNMENT AND MODIFICATIONS

Patient may not assign this Agreement. This Agreement replaces and supersedes all prior agreements of any kind, oral or in writing, between Patient and Practice. This Agreement may not be modified absent a writing signed by Patient and an authorized representative of Practice.

PATIENT ACKNOWLEDGES THAT HE/SHE HAS CAREFULLY READ THIS AGREEMENT, WAS AFFORDED SUFFICIENT OPPORTUNITY TO CONSULT WITH LEGAL COUNSEL OF HIS/HER CHOICE AND TO ASK QUESTIONS AND RECEIVE SATISFACTORY ANSWERS REGARDING THIS AGREEMENT, UNDERSTAND HIS/HER RESPECTIVE RIGHTS AND OBLIGATIONS UNDER IT, AND SIGNED IT OF HIS/HER OWN FREE WILL AND VOLITION.

By signing below, Patient agrees to participate in Practice's Wellness Exam Services under the terms of this Agreement as detailed above and in Schedule A.

PRACTICE:
PLACER PRIVATE PHYSICIANS, INC., A CALIFORNIA PROFESSIONAL CORPORATION

Signature: _____
Name/Title:_____
Date: _____

PRIMARY PATIENT
(and any patient over the age of 18):

Signature: _____
Printed Name:_____
Relationship to Primary:_____
Date: _____

Signature: _____
Printed Name:_____
Relationship to Primary:_____
Date: _____

Signature: _____
Printed Name:_____
Relationship to Primary:_____
Date: _____

SCHEDULE A
WELLNESS EXAM SERVICES & SERVICES FEES

1. Wellness Exams

Practice will provide to Patient the availability of one (1) annual, routine regardless of medical condition or necessity, comprehensive diagnostic physical wellness examinations focused on primary care health goals, and up to four (4) follow up routine Wellness Exams per year ("Wellness Exams"). The Wellness Exams are designed to identify health conditions and involve the diagnostic evaluation of treatment options based on evidence-based medicine. Wellness Exams are intended to create a baseline to support health education and progress toward health-related goals. Wellness Exams will include services such as laboratory testing, review of laboratory testing, psychological health evaluation, screening for vascular disease, lifestyle evaluation and guidance that incorporate nutrition and activity analysis, and Wellness Exam-based Patient education.

2. Health Data Plan

The Health Data Plan ("Health Data Plan") is designed to assist with storing Patient's Wellness Exams health data and to improve Patient's Wellness Exams-based electronic communication connection with Practice to facilitate Wellness Exams health goals and education as outlined above. The Health Data Plan will facilitate and empower Patient to interact with Practice via electronic communication regarding Practice's Wellness Exam Services. Practice's Health Data Plan will keep Patient's Wellness Exams medical information electronically stored so that, upon request of Practice, information can be retrieved and furnished to further support the Wellness Exam Services Patient receives from Practice on the terms outlined above.

3. Services Fees for existing members are grandfathered in based upon the date the member joined the practice. This contract does not affect or change those existing Service Fees. The current structure for New Members Service Fees now joining the practice will be:

$82.50 / month for individuals ages 0-19
$27.50 / month for individuals with at least one parent membership ages 0-19
$165.25 / month for individuals ages 20-55
$215.00 / month for individuals ages 56+

ADDITIONAL TERMS:

Due to the smaller patient panel size of the Practice, Practice anticipates Patient will enjoy little or no wait times for exams scheduling and related electronic Practice communications. Practice's healthcare professionals will also have the extended time and availability to provide unhurried visits to support ongoing health guidance and education. Due to the Health Data Plan, if applicable, Patients will enjoy direct and immediate communication with Practice using an electronic communications portal designed to achieve HIPAA/privacy compliance.

*For Medicare/Medicaid eligible patients, and with respect to any services other than the Wellness Exam Services identified above, Practice may deliver services specifically covered by applicable Plan at Patient's request and as medically indicated and consistent with those Plan's reimbursement requirements. Medicare patients may request and may potentially receive the Welcome To Medicare Checkup, the Annual Wellness Visit, chronic care management/CCM services, remote patient monitoring/RPM services, telehealth evaluation and management, and virtual check-up communication services—all such services are **not** part of the private Services Fee identified above. Any such additional services covered by any Plan are **not** the private fee Wellness Exam Services outlined above, and such services can and will be provided by Practice as indicated and billed to the applicable Plan to the extent Practice is in-network with such Plan. Applicable Plan-required co-payments and deductibles will be collected as required by Plan terms. In no event may Patient submit to Medicare or Medicaid any private fee paid for Wellness Exam Services, as Wellness Exam Services are **not** covered or reimbursed by Medicare or Medicaid.*

PLACER PRIVATE PHYSICIANS
ELECTRONIC COMMUNICATIONS AGREEMENT

Placer Private Physicians, Inc., a California professional corporation ("we", "us" or "Practice"), and the undersigned patient ("you" or "Patient") enter into this Electronic Communications Agreement ("EC Agreement") regarding the use of e-communications/transmissions, such as e-mail, mobile or cellular telephone, Skype, FaceTime, internet portal-enabled communications, or any other version of electronic communication (collectively "E-Communication") with respect to Patient protected health information ("PHI"). (Practice and Patient are each individually called "Party" or collectively as "Parties").

PATIENT AUTHORIZATION DESPITE RISKS OF PRIVACY BREACH

While Practice and Patient commonly rely on electronic communication platforms and services to achieve immediate communication, there are risks that you acknowledge that are outside the Practice's control. You authorize all forms of E-Communications exchanged between Parties unless you instruct us otherwise in writing. You acknowledge that the use of E-Communication is inherently risky and prone to unintentional release of data. E-Communications may incorporate or communicate references to your PHI with sensitive health and personal identification information included. You acknowledge that E-Communications lack any absolute guaranty of privacy and are subject to: system privacy failure, cookies and other tracking efforts, phishing attacks, hacking attacks, data breaches, unintended misdirections, misidentifications of senders/recipients, technology failures, and user errors.

You agree to undertake efforts to protect your privacy, which include refraining from including sensitive information in E-Communications that you do not want to be at risk of any data security breach. Practice will undertake reasonable efforts to protect your privacy to the extent required by applicable laws. You authorize us to respond electronically to all E-Communications that appear to be provided by you, whether or not such communications arrive from the electronic contact information that you provide us.

PATIENT MUST PROVIDE ACCURATE AND UPDATED CONTACT INFORMATION

You agree to provide us with your accurate electronic contact information (mobile telephone number for phone calls and text messaging, email address, Skype or FaceTime contact information, and any other applicable E-Communication contact information). You will immediately inform us of any changes or corrections to your electronic contact information as an effort to avoid misdirected E-Communications.

PATIENT MUST NOT RELY ON ELECTRONIC COMMUNICATION IN EMERGENCIES: USE 911 AND GET TO THE EMERGENCY ROOM

Practice does not guarantee that we will read your E-Communications immediately or within any specific amount of time. You agree not to utilize E-Communications to contact us regarding an emergency or time-sensitive situation, as there is too much risk that the communication response may be delayed, ineffective, untimely, or inadequate. You MUST call 9-1-1 in an emergency, immediately seek emergency medical attention, or both.

PRACTICE WILL COMPLY WITH HIPAA

The Practice values and appreciates your privacy and will take commercially reasonable steps to protect Patient's privacy in compliance with the Health Insurance Portability and Accountability Act of 1996 and related laws ("HIPAA").

We will obtain your express written or electronic consent (to the extent required by applicable law) if we are required or requested to forward your identifiable PHI to any third party other than as authorized in our Notice of Privacy Practices or as authorized or mandated by applicable law.

You hereby consent to the use of E-Communication of Patient's information as we consider it helpful to coordinate care and schedule mobile visits with you and all those responsible for providing or overseeing your care. You agree to identify individuals or entities authorized to receive your PHI from us in connection with authorized consulting, education, and all other aspects of your care, and we may share your PHI with such parties without additional written or electronic consent from you.

You have the right to ask us for a copy of your PHI, including an explanation or summary. These services that we perform will not be the subject of additional charges to you: maintaining PHI storage systems; recouping capital or expenses for PHI data access, PHI storage, and infrastructure; or retrieval of PHI electronic information.

We may charge you fees for actual costs that we incur to provide such electronic PHI, but only to the extent authorized by applicable laws. Such fees may include, to the extent lawful: skilled technical staff time spent to create and copy PHI; compiling, extracting, scanning, and burning PHI to media and distributing the media (with media costs charged to you); and time spent by our administrative staff preparing additional explanations or summaries of PHI. If you request PHI on a paper copy, or portable media (such as compact disc/CD, or universal serial bus/USB flash drive), we may charge you for our actual supply costs for such equipment, and you agree to pay us any such costs.

PATIENT ACCEPTS RESPONSIBILITY FOR ELECTRONIC COMMUNICATION RISKS

You will hold Practice (and our owners, officers, directors, agents, and employees) harmless from and against any and all demands, claims, and damages to persons or property, losses, and liabilities, including reasonable attorney fees arising out of or caused by E-Communication (whether encrypted or not) losses or disclosures caused by any of the risks outlined above, by some person or entity other than Practice, or not directly caused by us. Patient acknowledges and understands that, at our discretion, E-Communication may or may not become part of your permanent medical record. These terms do not relieve Practice from Practice's obligations to comply with all applicable E-Communication laws.

You acknowledge that your failure to comply with the terms of this EC Agreement may result in our terminating the use of E-Communication methods with you and may cause the termination of your Agreement for our services.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

We are required to provide you a copy of our Notice of Privacy Practices, which states how we may disclose your health information. You hereby acknowledge receipt of the Notice of Privacy Practices.

CONSENT TO DISCLOSURE OF BILLING INFORMATION

By signing this EC Agreement, you consent to Practice disclosing all information relevant to billing, insurance, and reimbursement regarding any and all substance abuse disorders that you might have, for the purpose of obtaining reimbursement from private or public insurers.

ADDITIONAL TERMS

This EC Agreement will remain in effect until either Party provides written notice to the other Party revoking this EC Agreement or otherwise revoking consent to E-Communications between the Parties. Such revocation will occur thirty (30) calendar days after written notice of such revocation.

Revocation of this EC Agreement will preclude us from providing treatment information in an electronic format other than as authorized or mandated by applicable law or by you. Either Party may use a copy of this signed original EC Agreement for all present and future purposes.

Parties agree to take such action as is reasonably necessary to amend this EC Agreement from time to time as it is necessary for the Parties to comply with the requirements of the Privacy Rule, the Security Rule, and other provisions of HIPAA, or other applicable law. Parties further agree that this EC Agreement cannot be changed, modified or discharged except by an agreement in writing and signed by both Parties.

If any term of this EC Agreement is deemed invalid or in violation of any applicable law or public policy, the remaining terms of this EC Agreement shall remain in full force and effect, and this EC Agreement shall be deemed amended to conform to any applicable law.

Each participating Patient (and authorized representative when applicable) must sign this EC Agreement. Your signature represents that you understand and agree to the terms and conditions described within this EC Agreement.

PRACTICE:
PLACER PRIVATE PHYSICIANS, INC.,
A CALIFORNIA PROFESSIONAL
CORPORATION

Signature: _____
Name/Title:_____
Date: _____

PATIENT:

Signature: _____
Printed Name:_____
Relationship to Patient:_____
Date: _____

PLACER PRIVATE PHYSICIANS
ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to undersigned patient ("Patient"):

Placer Private Physicians, Inc., a California professional corporation ("Practice"), is required to provide Patient with a copy of Practice's Notice of Privacy Practices ("Notice"), which states how Practice may use and/or disclose Patient's health information.

Please sign this form to acknowledge receipt of the Notice.
You may refuse to sign this acknowledgment if you wish.

I acknowledge that I have received a copy of Practice's Notice of Privacy Practices.

Patient's name (please print): _____
Signature: _____
Date: _____

FOR OFFICE USE ONLY

Practice made every effort to obtain written acknowledgment of receipt of the Notice of Privacy Practices from Patient but it could not be obtained because:

Patient refused to sign.

Due to an emergency, it was impossible to obtain an acknowledgment.

Practice was unable to communicate with Patient.

Other: _____
_____
_____

PLACER PRIVATE PHYSICIANS
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.

Dear Patient:

Placer Private Physicians, Inc., a California professional corporation ("we", "us", "our", "Practice"), understands that patient ("you", "your") privacy is important. This Notice of Privacy Practices ("Notice") applies to Practice and each of our Business Associates, as applicable.

Protected Health Information

Protected health information ("PHI") relates to information about you and your health, which could be used to identify you. Each time that you visit us, we create a medical record of your PHI and services that you receive.

Our Obligations Regarding Your Protected Health Information

We recognize that information about you and your health is confidential, and we are committed to protecting this information. This Notice applies to all your health records that we create.

We are required by law to preserve the privacy and security of your PHI. While there is no absolute guarantee of privacy, we are committed to protecting your privacy. We have established reasonable and appropriate measures to protect your PHI against unauthorized uses and disclosures.

Federal law mandates that we share this Notice with you, and that we make a good faith effort to obtain a signed document acknowledging your receipt of this Notice. We are also required to follow the terms of this Notice. In the event that we are involved in a breach of your PHI, we will immediately notify you.

Notice Effective Date and Potential Changes

This Notice became effective on December 1, 2020, and it applies to health records that we create for you. We reserve the right to change this Notice after the effective date. We can change the terms of this Notice, and the changes will apply to all the information we have about you. The new Notice will be available upon request.

How We May Disclose Your Protected Health Information

The laws of the state where Practice is located, and federal laws, allow disclosures of your PHI in some cases. Some of these disclosures do not require your verbal or written permission. The following information describes how we may share your PHI. We may typically use or share your PHI in these ways:

Treat you

We can use your PHI and share it with other professionals who are treating you.

- Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your PHI to run our Practice, improve your care, and contact you when necessary.

- Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your PHI to bill and obtain payment from health plans or other entities.

- Example: We give information about you to your health insurance plan so it will pay for your services.

Help with public health and safety issues

We can share your PHI for certain situations such as:

- Preventing disease;
- Helping with product recalls;
- Reporting adverse reactions to medications;
- Reporting suspected abuse, neglect, or domestic violence; and
- Preventing or reducing a serious threat to anyone's health or safety.

Perform research

We can use or share your PHI for health research.

Comply with the law

We will share your PHI if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we are complying with federal privacy law.

Respond to organ and tissue donation requests

We can share your PHI with organ procurement organizations.

Work with a medical examiner or funeral director.

We can share your PHI with a coroner, medical examiner, or funeral director when an individual dies.

Address other government requests

We can use or share your PHI:

- For workers' compensation claims;
- For law enforcement purposes or with a law enforcement official;
- With health oversight agencies for activities authorized by law; and
- For special government functions such as military, national security, and presidential protective services.

Respond to lawsuits and legal actions

We can share your PHI in response to a court or administrative order, or in response to a subpoena.

How else can we use or share your PHI?

We are allowed or required to share your PHI in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. We have not listed every use and disclosure in this Notice. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Use and Disclosure of Your PHI with Your Verbal Agreement

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

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care;
- Share information in a disaster relief situation; and
- Include your information in a hospital directory.

If you cannot tell us your preference, for example, if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to your health or safety.

Use and Disclosure of Your PHI Requiring Your Written Permission

If there are situations that have not been described above, we will obtain your written permission. In these cases, we never share your PHI unless you give us written permission:

- Marketing purposes;
- Sale of your information; and
- Most sharing of psychotherapy notes.

With fundraising, we may contact you for fundraising efforts, but you can tell us not to contact you again.

If you provide us with written permission, you may change your mind at any time. Please let us know in writing if you change your mind.

Your Rights Regarding Your PHI

You have the following rights regarding your PHI that is created in our Practice. This section explains some of your rights and our responsibilities to assist you.

Get an electronic or paper copy of your medical record

- You can ask to see or receive an electronic or paper copy of your medical record and other PHI that we have about you. Ask us how to do this.
- We will provide a copy or a summary of your PHI, usually within 30 days of your request. We may charge a reasonable cost-based fee.

Ask us to correct your medical record

- You can ask us to correct PHI about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request, but we will tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone), or to send mail to a different address.
- We will say “yes” to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain PHI in connection with our services.
- We are not required to agree to your request, and we may say “no” if it would affect your care.
- Because you are privately paying for some medical or health services, you may ask us to refrain from sharing information related to those private pay services with your health insurance plan. We will respect that request unless we are legally obligated otherwise under applicable laws.

Get a list of who we have shared information

- You can ask for a list (accounting) of the times we have shared your PHI for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, health care operations, and certain other disclosures (such as any you asked us to make).

- We will provide one accounting per year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this Notice

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

Choose someone to act for you

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

Ask questions or file a complaint if you believe your rights are violated

- If you have questions about this Notice or you believe that your rights are being violated, please contact us immediately:

Practice Contact Information:

Placer Private Physicians, Inc.
6960 Destiny Drive, Suite 100
Rocklin, CA 95677
Email: lisablumm@placermd.com

You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints.

Please provide as much information as possible so that the Department of Health and Human Services can thoroughly investigate your concern or complaint. We will not retaliate against you for filing a complaint with us, or the Department of Health and Human Services.

Thank you,

PLACER PRIVATE PHYSICIANS

PLACER PRIVATE PHYSICIANS

Personalized family and sports medicine

Placer Private Physician Authorization for Release of Medical Records

Previous Physician/Clinic Phone Number/Fax

Street Address

City, State, Zip

NOTICE:
Physicians, hospitals and health plans are required by law to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, state or federal confidential law may no longer protect it.

DISCLOSURE:
I understand that the recipient may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

YOUR RIGHTS:
This authorization to release health information is voluntary. The authorization shall become effective immediately and shall remain in effect one-year from the date of signature unless different date is specified here _____. Treatment, payment, enrollment of eligibility from benefits many not be conditioned on signing this authorization except in the following cases: (1) to conduct research-related treatment, (2) to obtain information in connection with eligibility or enrollment in a health plan, (3) to determine an entities obligation to pay a claim, or (4) to create health information to provide to third party. This authorization may be revoked at any time. The revocation must be in writing, signed by you or your patient representative, and delivered to Placer Private Physicians, Inc. The revocation will take effect the date we receive it. You are entitled to receive a copy of the authorization if you request it.

By signing below I hereby authorize the release of my medical records to the following physicians:

Brön Hedman, M.D.
Richard Lichti, M.D.
Lezley Brown, M.D.
Placer Private Physicians
6960 Destiny Drive, Suite 100
Rocklin CA 95677
Phone: (916) 624-1777
Fax: (916)624-1770

Specify Records:

☐ Medical Information

Signature Date

☐ Other Health Information (specify the records to be disclosed)

Specify records to be disclosed

Print Name **Birthday**

Signature (Patient/Parent/Guardian) **Date**

If signed by other than patient, indicate relationship

PLACER PRIVATE PHYSICIANS

Personalized family and sports medicine

Release of Medical Information to Family Members

Richard Lichti, M.D.
Brön Hedman, M.D.
Lezley Brown, M.D.
Placer Private Physicians
6960 Destiny Drive, Suite 100
Rocklin CA 95677

I authorize Placer Private Physicians to discuss and release all medical information to family members named below. This includes medical records, x-rays, history, findings and prognosis pertaining to the medical condition, service rendered, or treatment given to me. This authorization complies with the confidentiality of Medical Information Act, Section 56ET SEQ of the California Civil Code.

Emergency Contact	Relationship	Phone Number
Additional Contact	Relationship	Phone Number
Additional Contact	Relationship	Phone Number
Additional Contact	Relationship	Phone Number

Patient Name (Please Print)	Date of Birth
Patient, Parent/Guardian or Power of Attorney Signature	Date

PLACER PRIVATE PHYSICIANS

Personalized family and sports medicine

Brön Hedman, MD
drhedman@placermd.com
Rich Lichti, MD
drlichti@placermd.com
Lezley Brown, MD
drbrown@placermd.com
Baljit Sivia, MD
drsivia@placermd.com

Race and Ethnicity Identification Form

Hospitals and other healthcare facilities are required by law to provide the California Department of Health Care Access and Information (HCAI) with information regarding the race and ethnicity of their patient population. (California Health and Safety Code Division 107, Part 5, Sections 128735, 128736, and 128737.) The data will be used for health projects including diagnostic research, identification, and correction of disparities in healthcare access and outcomes, management of healthcare delivery and public health programs, quality of care, healthcare trends, and supporting informed decisions. Individually identifiable patient information is protected and encrypted within the State system.

Name: _____ Date of Birth_____

INSTRUCTIONS: The two questions below are designed to identify your ethnicity and race. Please answer both questions completely.

Part 1: Ethnicity Designation

Are you Hispanic of Latino? (A person of Cuban, Mexican, Puerto Rico, South or Central American, or other Spanish culture or origin, regardless of race.)

☐ YES ☐ NO

Part 2: Race Designation

Please select the racial category or categories with which you most closely identify.

☐ **American Indian or Alaskan Native:** A person having origins in any of the original peoples of North or South America (including Central America), and who maintains a tribal affiliation or community attachment.

☐ **Asian:** A person having origins in any of the original peoples of the Far East, South East Asia or the Indian subcontinent including Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

☐ **Black or African American:** A person having origins in any of the black racial groups of Africa.

☐ **Native Hawaiian or Other Pacific Islander:** A person having origins in any of the original peoples of Hawaii, Guam, Samoa or other Pacific Islands.

☐ **White:** A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

I verify the information on this form is accurate. I decline to answer this form.

_____ ___/___/___ _____ ___/___/___

Signature *Date* *Signature* *Date*

Chronic Opiate Therapy Declaration to All New Placer Private Physician Patients

Thank you for considering Placer Private Physicians for your new primary care home. We take chronic pain seriously and understand how much it can adversely affect a person's life. That is why we recommend a multi-dimensional approach to chronic pain including medications, exercise, nutrition, and stress reduction.

Opiate therapy can be a crucial component to treating chronic pain. However, as you are probably aware, there has been a trend of overprescribing and abuse of these powerful medications. There is currently an opiate epidemic in the US with countless overdose victims and drug dependence. These medications need to be cautiously prescribed and monitored. And in many cases, the current dosage needs to be decreased or discontinued all together.

In light of this information, the Placer Private Physicians will not take on the prescribing of chronic opiate medication for new patients. We are not saying that we are refusing to work with you to help alleviate your pain and improve your daily function. However, you will need to have an established pain specialist monitor and prescribe your opiate medications. Under the right circumstances, we may agree to refill a onetime 30 to 90 day supply until you are able to establish care.

Thank you for your understanding and we look forward to serving as your primary care physicians. If you have questions about our policy or your specific case, please notify our staff and we will arrange a physician review.

Sincerely,

Brön Hedman, MD

President - Placer Private Physicians

Rich Licthi, MD

Vice President - Placer Private Physicians

I acknowledge that I have read and understand these terms.

Patient Name:_____

Patient Signature: _____

Date:_____