PATIENT ACCOUNT REGISTRATION

Name _____ ☐ Male ☐ Female
Date of Birth _____ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed
Address _____ City / State / Zip _____
Home Phone _____ Business Phone _____
Cellular Phone _____ Driver's License Number _____
Social Security Number _____ Referred by _____
Employer's Name _____
Employer's Address _____

RESPONSIBLE PARTY

☐ Check here if same as patient information and skip to insurance information

Name _____ ☐ Male ☐ Female
Address _____
Home Phone _____ Business Phone _____
Cellular Phone _____

PRIMARY INSURANCE INFORMATION

Name of Insurance Plan _____ ☐ HMO ☐ POS ☐ PPO ☐ Other
Insurance ID # _____ Group # _____
Address _____ City / State / Zip _____
Name of Insured _____ Employer _____
Date of Birth of Insured _____ SSN of Insured _____
Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Parent ☐ Other (specify) _____

SECONDARY INSURANCE INFORMATION

Name of Insurance Plan _____ ☐ HMO ☐ POS ☐ PPO ☐ Other
Insurance ID # _____ Group # _____
Address _____ City / State / Zip _____
Name of Insured _____ Employer _____
DOB of Insured _____ SSN of Insured _____
Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Parent ☐ Other (specify) _____

EMERGENCY CONTACT INFORMATION

Name _____ Relationship _____
Phone Number _____ Can we tell this person what is wrong with you? ☐ Yes ☐ No

DISCLOSURE – Please read carefully and sign.

I hereby assign my insurance benefits to be made directly to the doctor and/or his/her associates, for services rendered. I hereby attest that the above insurance information is accurate and that I am an eligible member of the stated plan. I understand that I am responsible for knowing my benefits/coverage. I will be financially responsible for all charges that are NOT covered by my insurance company. I also agree to paying all co-payments, co-insurances and/or elective service fees at the time of service. If there are problems collecting payment, attorney's fees, collection agency costs and any related fees will be added to my bill.

I authorize the release of all information other physicians and insurance carriers upon request for the purpose of payment for medical services and further treatment of care by another physician. I further agree that a photocopy of this agreement shall be as valid as the original.

I hereby acknowledge that I have read, understand and agree to hereby give consent to assess, treat and test.

Signature _____ Date _____
☐ Patient ☐ Parent ☐ Child ☐ Legal Guardian ☐ Durable Power of Attorney ☐ Other (specify) _____

Ann L. Mai, M.D.
4950 Barranca Parkway, Suite 207 Irvine, California 92604
Phone (949) 262-9700 – (949) 262-0700 Fax
J. Stephen Wikle, M.D.

PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: **Agreement to Arbitrate:** It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: **All Claims Must be Arbitrated:** It is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or service provided by the physician including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partners, associates, association, corporation or partnership, and the employees, agents and estates of any of them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim.

Article 3: **Procedures and Applicable Law:** A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, not supplant, any other applicable statutory or common law.

Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Sections 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrators a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure section 1283.05, however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: **General Provisions:** All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: **Revocation:** This agreement may be revoked by written notice delivered to the physician within 30 days of signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

Article 6: **Retroactive Effect:** If patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial below:

Effective as of the date of first medical services

_____
Patient's or Patient Representative's Initials

If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

By: _____ _____
Physician's or Authorized Representative's Signature (Date)

_____
Print or Stamp Name of Physician, Medical Group or Association Name

By: _____ _____
Patient's or Patient Representative's Signature (Date)

By: _____
Print Patient's Name

_____
(If Representative, Print Name and Relationship to Patient)

A signed copy of this document is to be given to the Patient. Original is to be filed in Patient's medical records.

FINANCIAL LIABILITY AGREEMENT

_____ I understand that all co-payments, co-insurances and deductibles are due at the time of service. We do not accept a 'bill me later policy'.
There are NO EXCEPTIONS.

_____ I understand that if my insurance does not issue payment within 90 days of the date of service I will be financially responsible for the entire balance. I may pursue my insurance carrier at that time to render payment and once settled, if due, I will receive a refund for any overpayment.

_____ I understand that it is my responsibility to inform this office of any changes in my insurance coverage. This office WILL NOT re-bill my insurance if I fail to keep the office updated with my most current insurance information. We ask you at EVERY VISIT if there is any change, please keep us updated.

_____ I understand that this office DOES NOT verify benefits at the time of service. I am responsible for knowing my benefits and will be responsible for contacting my insurance carrier for details. We DO NOT do this for you.

_____ I understand that I will be financially responsible for all services rendered that are NOT covered by my insurance. This includes office visits for 'behavioral health' issues ('worries', stress, depression, anxiety...) that are often NOT a covered benefit by HMO plans and many PPOs. You may see a psychiatrist to ensure coverage.

_____ I understand that if I violate any terms of this FINANCIAL LIABILITY AGREEMENT I and all immediate family members will be discharged from this practice. I will be held financially responsible for any balance remaining on all accounts (mine and my family's) plus any associated collection and attorney fees.

Signature: _____

Print Name: _____ Date: _____

Ann L. Mai, M.D. 4950 Barranca Parkway, Suite 207 Irvine, California 92604 J. Stephen Wikle, M.D.
Phone (949) 262-9700 – (949) 262-0700 Fax

TEST RESULTS NOTIFICATION

Dear Patient,

We will notify you of your test results, including X-rays, blood work, Pap smears, etc... This process takes approximately TWO weeks. If indicated, we will contact you *sooner* by telephone regarding the results and/or follow-up instructions.

Mammogram results will be mailed directly by the radiology office. We WILL NOT email or mail out these results.

HIV results can only be obtained by making a follow up visit with the doctor. We cannot email or mail these results. This complies with California State Law. There are no exceptions.

To obtain results, please register at www.relayhealth.com and set up a new account. We will email your results through this website. WE DO NOT EMAIL TO YOUR PRIVATE EMAIL ACCOUNT!

We will also mail out results to you if you do not register online. However, this may take MORE TIME (and you will receive your results later).

Please wait TWO (2) weeks from the date of the test(s) performed before you contact our office for the results. Our staff is not permitted to release any results by telephone.

If you would like to discuss your results, please make an appointment with this office or consult the doctor with a webVisit at www.relayhealth.com (there is a fee for this).

_____ I authorize my physician and/or the staff to leave messages on my answering machine, voice mail, or with a family member.

Family member to exclude: _____

_____ I request that NO messages be left at any of my numbers. I take full responsibility to make a follow up visit with this office to obtain any of my results.

Signature: _____

Print Name: _____ Date: _____

Ann L. Mai, M.D. 4950 Barranca Parkway, Suite 207 Irvine, California 92604 J. Stephen Wikle, M.D.
Phone (949) 262-9700 – (949) 262-0700 Fax

ANNUAL HEALTH UPDATE

Name: _____ **Date of Birth:** _____
Reason for Visit: _____ **Date of Visit:** _____
Current prescription medications, vitamins or supplements:

_____

_____

Allergies: _____

PAST MEDICAL HISTORY

*Please check if **YOU** have or had the following:*

☐ Measles ☐ Asthma ☐ Heart attacks
☐ Mumps ☐ Emphysema ☐ Rheumatic fever / heart disease
☐ Chickenpox ☐ Strokes ☐ Sexually transmitted disease(s)
☐ Birth defects ☐ Diabetes ☐ Tuberculosis
☐ Cancer type: _____
☐ Injuries ☐ Broken bones details/date: _____
☐ Head concussions or injuries details/date: _____
☐ Hospitalization(s) _____
☐ Anesthesia ☐ Local ☐ Regional ☐ General ☐ Other / Unknown
☐ Operations _____
☐ Car accident(s) date(s): _____
☐ Other serious conditions _____

FAMILY HISTORY

*Please check if **any blood relative** has ever had:*

☐ Breast cancer (who: _____) ☐ Colon cancer (who: _____)
☐ Other cancers (_____) ☐ Mental illness (anxiety / depression / other)
☐ Bleeding tendencies ☐ Osteoarthritis / Gout
☐ Diabetes ☐ Seizures
☐ Heart disease / heart attacks ☐ Strokes
☐ High blood pressure ☐ Tuberculosis
☐ High cholesterol ☐ Other _____

RELATIVE	IF LIVING		IF DECEASED	
	Age	Health	Age	Cause of Death
Father				
Mother				
Sibling(s) M/F				
M/F				
Spouse				
Children M/F				
M/F				

SOCIAL HISTORY

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Other
Are you sexually active? ☐ Yes ☐ No If yes, ☐ with males ☐ with females ☐ with both
Are you living with your spouse/partner? ☐ Yes ☐ No Is your sex life satisfactory? ☐ Yes ☐ No
Are there dependents at home? ☐ Yes ☐ No Children / Grandchildren / Other
Do you drink alcohol? ☐ Yes ☐ No How much? _____ How often? _____
Do you smoke now? ☐ Yes ☐ No How much? _____ How often? _____
Did you ever smoke? ☐ Yes ☐ No Amount / Quit date? _____
Do you use drugs? ☐ Yes ☐ No How much / often? _____
Do you have pets? ☐ Yes ☐ No Please list: _____
Do you exercise regularly? ☐ Yes ☐ No Do you have an advance directive? ☐ Yes ☐ No
Are you employed? ☐ Full-time ☐ Part-time ☐ Unemployed Occupation: _____
Time lost due to health reasons: In past 6 mos? _____ past yr: _____ past 5 yrs: _____

(OVER PLEASE)

REVIEW OF SYSTEMS

*Please **CIRCLE** if you have any of the following **NOW** and answer questions with blanks:*

GENERAL: Fever Chills Weight loss Weight gain Fatigue Appetite change Insomnia

SKIN: Acne Jaundice Hives Eczema Psoriasis Rashes Boils Abnormal pigmentation

HEAD/EYES/EARS/NOSE/THROAT: Headaches Eye disease or injury Glasses Contacts
Double vision Blurry vision Glaucoma Itchy eyes Runny nose Sneezing
Nosebleeds Chronic sinus trouble Ear disease Poor hearing Dizziness

NECK: Stiffness Enlarged glands Thyroid trouble

RESPIRATORY: Frequent colds Spitting up blood Cough Asthma/Wheezing Emphysema
Difficulty breathing Shortness of breath Pain with breathing Pleurisy Pneumonia

CVS: Chest pain Shortness of breath at rest / with activity Awakening in night smothering
Difficulty walking two blocks Swelling of hands / feet / ankles High blood pressure
Heart murmur Valvular heart disease Palpitations

DIGESTIVE SYSTEM: Food sticks in throat Heartburn/Indigestion Ulcer Nausea Vomiting
Vomiting blood Gallbladder disease Liver trouble Hepatitis Cramping Gas/Bloating
Diarrhea Constipation Painful stools Hemorrhoids Bloody stools Black stools

GYNECOLOGICAL: Age periods started: ____ How long do periods last? _____
Frequency of periods: Every _____ days Painful periods PMS Menopause
Birth control _____ Hysterectomy (date / reason: _____)
Number of pregnancies _____ Number of abortions/miscarriages _____
Date of last period _____ Last Pap _____ Normal / Abnormal
Date of last mammogram _____ Normal / Abnormal
Have you ever had an STD? □ No □ Yes _____
List all hormones taken (past/present) _____

GENITOURINARY: Kidney stones Loss of urine Frequent urination Burning/painful urination
Blood in urine Vaginal / Urethral discharge Circumcised? Y / N Testicular pain / swelling

MUSCULOSKELETAL: Varicose veins Weakness of muscles or joints Difficulty walking
Pain or swelling of joints Back pain (where? _____chronic? Y / N)
Scoliosis Pain in buttock/calves while walking, relieved with rest

ENDOCRINE: Thyroid disease Change in hat/glove size Hair loss Always hot / cold
Current wt _____ Current height _____ Dry skin Coarse hair

HEMATOLOGIC: Slow healing Easy bruising Anemia Phlebitis Blood Clots

NEUROPSYCHIATRIC: Lightheadedness Fainting spells Numbness Tingling Paralysis
Weakness Convulsions/Seizures Under a lot of stress Anxiety Depression Bipolar
Suicide Attempts Disinterest in usual activities Hopelessness Worthlessness
Poor concentration Anorexia Bulimia

PREVENTIVE: Last tetanus shot _____ Last flu shot _____
Last pneumonia shot _____ Last screen for colon cancer _____
Last prostate exam _____ Last PSA _____
Name & number of your dentist _____

Patient's signature: _____ Date: _____

Reviewed by: _____ Date: _____

ANN MAI, M.D. and J. STEPHEN WIKLE, M.D.
4950 Barranca Parkway, Suite 207 ☼ Irvine, California 92604
Tel (949) 262-9700 ☼ (949) 262-0700 Fax

NOTICE OF PRIVACY PRACTICES
Effective: April 14, 2003

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ AND REVIEW IT CAREFULLY

OUR PLEDGE
The protection of our patients' privacy and the confidentiality of their medical information has always been important to us. We understand that you trust us to safeguard your personal information and respect your right to privacy. This notice represents our commitment to maintain the privacy of your protected health information and to inform you of our legal duties and privacy practices, as well as your rights, as required by California and federal law. We are legally required to provide you a copy of this notice and to follow the terms of this notice currently in effect.

YOUR PERSONAL INFORMATION
We keep records of the medical care we provide you and we may receive similar records from others. We use this information so that we, or other health care providers, can render quality medical care, obtain payment for services and enable us to meet our professional and legal responsibilities to operate our medical practice. We may store this information in a chart and in our computers. This information makes up your medical record. The medical record is our property; however this notice explains how we use information about you and when we are allowed to share that information with others.

OUR PRIVACY PRACTICES
It is our policy to maintain reasonable and feasible physical, electronic and process safeguards to restrict unauthorized access to and protect the availability and integrity of your health information.

Our protective measures may include secured office facilities, locked file cabinets, managed computer network systems and password protected accounts.

Access to health information is only granted on a "need-to-know" basis. Once the need is established the access is limited to the minimum necessary information to accomplish the intended purpose.

Our staff are required to comply with the policies and procedures designed to protect the confidentiality of your health information. Any staff that violate our privacy policy are subject to disciplinary action.

HOW WE MAY USE OR SHARE YOUR INFORMATION
The following categories describe situations where the law allows us to use and share your health information. We give examples for each category that illustrate that type of use or disclosure. Not every use or disclosure is listed, but the ways in which we are legally permitted to use and share your health information will fall into one of these categories.

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

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.

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

Health Care Operations
We may use and disclose medical information about you to properly operate and manage our medical practice. For example, we may use and disclose this information to review and improve the quality of the care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud, waste and abuse detection, compliance programs and business planning and management. We may also share your health information with our business associates, such as our billing service, that perform services for us. However we will not share your health information with them unless they agree in writing to protect the privacy of that information. 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 providers, clearing houses 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 healthcare 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, waste and abuse detection and compliance efforts.

Notifications
We may disclose information to someone who is involved with your care or helps pay for your care. 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 also disclose information to a relief organization so that they may coordinate these notification efforts.

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, or to provide you with small gifts. We may also encourage you to purchase a product or service when we see you.

Research
Under certain circumstances, we may use and disclose medical information about you for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another, for the same condition. All research projects, however, are subject to a special approval process.

Special Circumstances and the Law
Special situations and certain laws may require us to use or release your health information. For example, we may be required to release your health information to others for the following reasons:

- Whenever we are required to do so by law; 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 occupation related injury or illness to the employer or Workers' Compensation insurer.
- To report information to agencies that regulate our business, such as the U.S. Department of Health and Human Services and the California Department of Health and Managed Care.
- To assist with public health activities; for example, we may report health information to the Food and Drug Administration for the purpose of investigating or tracking a prescription drug and medical device malfunctions.
- To report information to public health agencies if we believe there is a serious threat to your health and safety or that of another person or the general public; this includes disaster relief efforts

- To report certain activities to health oversight agencies; for example, we may report activities involving audits, inspections, licensure and peer reviews
- To assist courts or administrative agencies; for example, we may provide information pursuant to a court order, search warrant or subpoena, or when required by the investigation of a duly authorized administrative agency
- To support law enforcement activities; for example, we may provide health information to law enforcement agents for the purpose of identifying or locating a fugitive, material witness or missing person
- To correctional institutions, law enforcement officials or military authorities that have you in their lawful custody
- To report information to a government authority regarding child abuse, neglect or domestic violence
- To share information with a coroner or medical examiner as authorized by law. We may also share information with funeral directors, as necessary to carry out their duties.
- To use or share information for procurement, banking or transplantation of organs, eyes or tissues
- To report information regarding job-related injuries as required by your state workers' compensation laws
- To share information related to specialized government functions, such as military and veterans activities, national security and counter-intelligence purposes, or in support of providing protective services for the President, foreign heads of state and other designated persons
- To a family member or friend under any of the following circumstances: (1) if you provide a verbal agreement to allow such a disclosure; (2) if you are given an opportunity to object to such a disclosure and you do not raise an objection; or (3) if it can be inferred from the circumstance, based on our professional judgment, that you would not object.
- In the event that our practice is sold or merged with another organization, your medical 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.
- We may use or share your health information when it has been "de-identified." Health information is considered de-identified when it has been processed in such a way that it can no longer personally identify you.
- We may also use a "limited data set" that does not contain any information that can directly identify you. This limited data set may only be used for the purposes of research, public health matters or health care operations. For example, a limited data set may include your city, county and zip code, but not your name or street address.

YOUR WRITTEN PERMISSION

Except as described in this Notice of Privacy Practices, or as otherwise permitted by law, we must obtain your written permission – called an authorization – prior to using or sharing health information that identifies you as an individual. If you provide an authorization and then change your mind, you may revoke your authorization in writing at any time.

Once an authorization has been revoked, we will no longer use or share your health information as outlined in the authorization form; however you should be aware that we won't be able to retract a use or disclosure that was previously made in good faith based on what was then a valid authorization from you.

Except as specified above, under California law we may not share your health information with your employer or benefit plan unless you provide us an authorization to do so.

OTHER RESTRICTIONS

In California there may be additional laws regarding the use and disclosure of health information related to HIV status, communicable diseases, reproductive health, genetic test results, substance abuse, mental health and mental retardation. Generally we will be bound by whatever law is more stringent and provides more protection for your privacy.

YOUR RIGHTS

The following are your rights with respect to your health information. You have the right to:

- Ask us to restrict how we use or share your health information for treatment, payment or health care operations. You also have the right to ask us to restrict health information that we have been asked to give to family members or to others who are involved in your health care or payment for your health care. Please note that while we will try to honor your requests, we are not required by law to agree to these types of restrictions;
- Request confidential communications of health information. For example, you may ask that we send information to your work address. We will accommodate all reasonable requests submitted in writing;
- Inspect and copy your health information, with limited exceptions. To access your record, 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 may charge you a reasonable fee for copies as allowed by law. Under certain circumstances we may deny your request. If we do deny your request, we will notify you in writing and may provide you the opportunity to have the denial reviewed;
- Request an amendment to your health information that you believe is incorrect or incomplete. We may require your request be in writing and that you provide a reason for the request. If we make the amendment, we will notify you. If we deny your request, we will notify you of the reason in writing. This written notification will explain your right to file a written statement of disagreement. In return, we have a right to rebut your statement. Furthermore, you have the right to request that your initial written request, our written denial and your statement of disagreement be included with your health information for any future disclosures;
- Receive an accounting of certain disclosures of your health information made by us during the six years prior to your request. We may require that your request be in writing. Your first accounting is free. Subsequently, you are allowed one free accounting request every 12 months. If you request an additional accounting within 12 months of receiving your free accounting, we may charge you a fee. Please note that we are not required to provide you with an accounting for any information:
  - Disclosed prior to April 14, 2003;
  - Shared for treatment, payment or health care operations as described above;
  - Previously disclosed to you;
  - Shared as part of an authorization request;
  - Incidental to a use or disclosure that is otherwise permitted;
  - Provided for use in a facility directory;
  - Provided to persons involved in your care or for other notification purposes;
  - Shared for national security or counter-intelligence purposes;
  - Shared or used as part of a limited data set for research, public health or health care operations purposes;
  - Disclosed to correctional institutions, law enforcement officials, military authorities, or health oversight agencies.

CHANGES

Should any of our privacy practices change, we reserve the right to change the terms of this notice and to make the new notice effective for all the health information that we maintain, regardless of when it was created or received. We will provide you a copy of the revised notice and will post it publicly as required by law.

QUESTIONS OR COMPLAINTS

If you have any questions regarding this notice of privacy practices, if you require additional information, or you believe your privacy rights have been violated, please contact our Privacy Officer at:

4950 Barranca Parkway, Suite 207
Irvine, CA 92604
(949) 262-9700

No action will be taken against you and you will not be penalized in any way for filing a complaint with us.

If you prefer, you may direct your complaints to the Secretary of the United States Department of Health and Human Services.

Ann L. Mai, M.D. and J. Stephen Wikle, M.D.
Internal Medicine
4950 Barranca Parkway, Suite 207
Irvine, California 92604
Phone (949) 262-9700 - (949) 262-0700 Fax

Acknowledgement of Receipt of Notice of Privacy Practices

Privacy Officer: Michelle Eibl (949) 262-9700 Effective Date: April 14, 2003

Name of Patient: ______________________________ DOB: ____________

I hereby acknowledge that I received a copy of the Notice of Privacy Practices for the above physicians. 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.

Signature: ______________________________ Date: ____________________

Print Name: ______________________________ Telephone: ________________

If not signed by the patient, please indicate relationship:

- ☐ parent or guardian of a minor patient
- ☐ guardian or conservator of an incompetent patient
- ☐ beneficiary or personal representative of deceased patient

¤¤

Notice of Privacy Practices Acknowledgement Tracking Information

Complete the following only if the patient *refuses* to sign the Acknowledgement:

Efforts to Obtain: ____

Reasons for Refusal: ____

____

Employee Name: ____

RECORDS RELEASE

TO: ____

Name of Doctor / Medical Group or Clinic

____

Address / City / State / Zip

____

Telephone / Fax

¤¤

I HEREBY AUTHORIZE AND REQUEST YOU TO RELEASE TO:

☐ **Ann L. Mai, M.D.** ☐ **J. Stephen Wikle, M.D.**

4950 Barranca Parkway, Suite 207
Irvine, California 92604
Phone (949) 262-9700 -- (949) 262-0700 Fax

THE COMPLETE MEDICAL RECORDS IN YOUR POSSESSION, FOR PERIOD FROM ______________ TO ______________. If there is a charge for this service I (the patient) am responsible for the fee. Do not bill my new doctor's office.

Name of Patient: ______________________________ DOB: ______________

Patient's SSN: ______________________________ Telephone: ______________

Patient's Current Address: ______________________________________

Address / City / State / Zip

Signature: ______________________________ Date: ______________

Print Name: ______________________________

If not signed by the patient, please indicate relationship:

- ☐ parent or guardian of a minor patient
- ☐ guardian or conservator of an incompetent patient
- ☐ beneficiary or personal representative of deceased patient

Witness Signature: ______________________________

Witness Name: ______________________________