IVAN LAPIDUS, D.D.S., INC.

Periodontics / Dental Implants
Orofacial Pain & Dysfunction

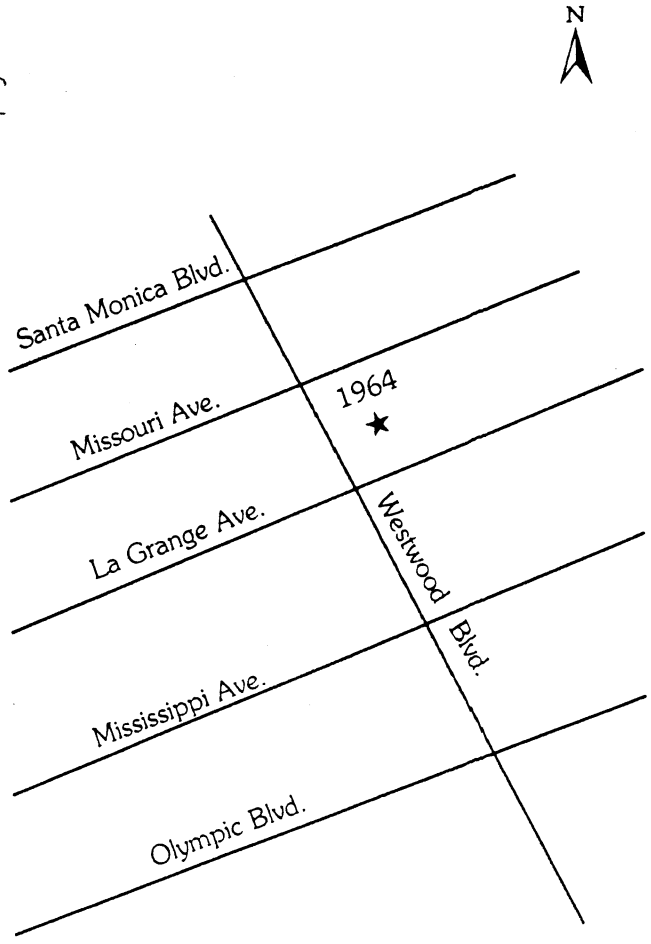
1964 WESTWOOD BOULEVARD
SUITE 200
LOS ANGELES, CALIFORNIA 90025-4651

TELEPHONE (310) 446-4867
FAX (310) 446-4715

Welcome!

Please complete and sign all enclosed forms except the insurance claims, just sign. Bring all forms in with you at your visit. There is no need to mail them back to us. We look forward to seeing you!

Dr. Ivan Lapidus & Staff



Provider: Dr Ivan Lapidus (310) 446-4867

Medicare Non-Participating Provider Agreement for

Patient (please print): _____

Please read each statement and initial it.

___ 1. I understand that by signing this agreement, I give up all Medicare payment options for services furnished by the above named doctor.

___ 2. I understand and agree not to bill Medicare or ask the physician to bill Medicare for these services.

___ 3. I understand that I am liable for all of the agreed to service charges (without any Medicare balance billing limits being in place).

___ 4. I understand and acknowledge that Medigap or any other supplemental insurance will not pay toward these services.

___ 5. I understand and acknowledges that I have right to receive services from another physician or dentist for whom Medicare coverage and payment would be available.

_____

Patient's Signature Date

_____

Doctor's Signature Date

_____

Witness's Signature Date

Patient:_____ Page 1

MEDICAL HEALTH QUESTIONNAIRE

For your welfare and our efficiency in diagnosis and treatment, please answer the following CONFIDENTIAL questions and briefly explain your answers.

How is your general health?_____Age_____

Date of last physical examination_____Height_____Weight_____

Are you being treated by a physician now? If yes, for what reason_____
_____

Are you taking any medications listed below?
antibiotics_____anticoagulants(blood thinners)_____tranquilizers_____
insulin_____blood pressure medicine_____cortisone_____
hormones_____heart medicine_____other_____

Have you been seriously ill or hospitalized? If so, when and for what reason_____
_____

Are you on a special diet?_____Are there any foods you do not eat?_____

Do you take supplemental vitamins?_____

Do you have now or have you ever had the following heart problems?
Rheumatic fever_____chest pain_____heart murmur_____stroke_____Heart attack___
high/low blood pressure_____shortness of breath_____other_____

Do you have or have you ever had the following infectious diseases?
Hepatitis____type_____Tuberculosis_____Syphilis_____Gonorrhea_____Measles_____
Mumps_____Chicken pox_____German measles_____AIDS/HIV_____other_____

Do you have any of the following?
liver disorders_____arthritis_____headaches_____high/low blood sugar_____
kidney disorder_____anemia_____dizziness_____lung problems_____
cancer_____Glaucoma_____Epilepsy_____ulcer_____
Diabetes_____depression_____Obstructive Sleep Apnea/Snoring_____
asthma_____sinus problems_____other_____

Have you ever experienced abnormal bleeding following extractions, surgery, injury or menstruation?_____

Have you ever had a blood transfusion?_____

Are you allergic, or have you had an unusual reaction to any of the following?
dental anesthetic_____penicillin_____barbiturates_____codeine_____
sulfa drugs_____aspirin_____tylenol_____other_____

Is there any history of family (genetic) diseases which may affect you?_____

Do you have any disease or disorder not listed above that we should know about?_____

_____

Women: Are you pregnant?_____If so, _____months

Do you smoke?_____cigarettes_____packs/day_____cigars_____#/day_____

Do you drink alcohol?_____If yes, how much/often_____

****

Patient_____Marital Status_____

Date of birth_____Social Security Number_____

E-mail Address_____Cell Phone ( )_____

Home Address_____Home Phone( )_____

City_____State_____Zip_____

Patient Occupation_____

Patient Employed By_____Business Phone( )_____

Spouse's Name_____

Spouse Employed By_____Business Phone( )_____

Party Responsible for this Account_____

Name and Address of Closest Relative_____

Referred By_____

Patient's Dentist_____Phone( )_____How Long_____

Patient's Physician_____Phone( )_____

Insurance Plan Name (Medical)_____(Dental)_____

****

DENTAL HISTORY

Has your care been: Regular_____Intermittent_____Infrequent_____

When did you last see a dentist?_____

Are your apprehensive about visiting our office?_____

Approximate date your teeth were last cleaned_____Frequency, every____months

How often do you brush your teeth daily?_____

What aids do you use to clean your teeth and gums? brush____floss____waterpik_____

Were you ever treated for: Periodontic(gums)_____Orthodontic(braces)_____
Endodontic(root canals)_____Oral Surgery_____

Are you dissatisfied with your appearance of your teeth?___________________________

Have you ever experienced any of the following?
bleeding gums___________pus around the teeth___________foul odor____________
swollen gums_____________loose teeth___________bad breath or taste___________
painful gums______spaces between teeth_______food packing between teeth______
receding gums__________drifting teeth__________high or rough fillings___________

Is there sensitivity in your teeth to:
hot________________sweet____________________tooth brusing__________________
cold_________________biting____________________pressure____________________

Have you ever had any injury to your head or neck?_______________________________

Do you clench or grind your teeth during the night/day?____________________________

Do you suffer from severe headaches, neck or back pain?___________________________

Do you have ear pain or pain in front of the ears?_________________________________

Does your jaw feel tired after a big meal?____

Is your sleep disturbed by pain of the head or neck region?_________________________

Are your daily activities disturbed by pain of the head and neck?____________________

Do you hear noise in the jaw joint with opening, closing, talking, or chewing?_________

Do you have any restriction in jaw opening?_______________________________________

____________________________________ ____________________
Patient's Signature **Date**

****

AUTHORIZATION FOR RELEASE OF MEDICAL/DENTAL INFORMATION

I____________________________, do hereby authorize and request (Dr., Mr., Mrs.) _____________________________________to release the medical, psychosocial, and dental records to Dr. Ivan Lapidus. I do hereby authorize Dr. Ivan Lapidus to discuss my treatment with referring practitioners whom I have seen in the past, am currently seeing or whom I potentially will see if he deems it necessary to adequately render treatment. Charges may be made for consultations with other practitioners in this regard. I also give Dr. Lapidus and his staff, consent to bill my insurance company and consent to call me on my cell or home phone, email me or text me to discuss my account and / or insurance information. <u>I will inform Dr. Lapidus in writing if I wish to revoke this release.</u>

Witness______________________________Patient________________________________
Date_________________

Type of information requested:

____
____

IVAN LAPIDUS, D.D.S., INC.

Periodontics / Dental Implants
Orofacial Pain & Dysfunction

1964 WESTWOOD BOULEVARD
SUITE 200
LOS ANGELES, CALIFORNIA 90025

TELEPHONE (310) 446-4867
FAX (310) 446-4715
E-mail: ivanlapidus@aol.com

****

PROFESSIONAL SERVICE AGREEMENT

Patient Name:_____

1. I hereby authorize Dr. Ivan Lapidus to perform all procedures which are stated below and which he has determined to be in the best interest of my dental oral health. I have been explained options to this treatment and all complications which could be reasonably expected.

2. Appointments are reserved for you. For non surgical appointments we require notification of at least forty-eight (48) business hours if a cancellation is necessary. In the event that a cancellation without such notice is made, a minimum charge of $65.00 up to a maximum charge equal to the fee for the service which was not performed will be assessed to your account. For surgical appointments we require notice of at least seventy-two (72) business hours if a cancellation is necessary. In the advent that a cancellation without such notice is made, a charge of $250.00 per hour of surgical time reserved will be assessed to your account. No charges will be assessed upon the first late cancellation. Please keep this in mind when scheduling appointments.

3. PAYMENT IS DUE IN FULL AT THE TIME OF SERVICE.

4. Fees are subject to change periodically. You will be informed of any changes in the fee for a procedure prior to the time of service. The current fee will be charged unless otherwise agreed upon prior to the date of service.

_____

_____

_____

_____

_____

_____

_____

***The fees for services I have discussed with Dr. Lapidus are noted above. I understand that by signing this form there is no obligation to follow through with these procedures. A copy of this form will be kept in your file for future reference.**

Patient Signature:_____

Date:_____

IVAN LAPIDUS, D.D.S., INC.

Periodontics / Dental Implants
Sleep Apnea
Orofacial Pain & Dysfunction

1964 WESTWOOD BOULEVARD
SUITE 200
LOS ANGELES, CALIFORNIA 90025

TELEPHONE (310) 446-4867
FAX (310) 446-4715

Dear UCLA Medical Group HMO Patient,

You have been referred to our office for management or your Orofacial pain/sleep apnea. We will be more than happy to submit the work you require to your insurance carrier and Medical Group, but please be informed that any charges ***not*** covered by your insurance plan ***will be your responsibility to pay***. We will make sure we have all work authorized prior to your appointments, but you are ***responsible for any unpaid charges*** by the insurance or medical Group. Orofacial/Sleep Apnea treatment is billable under ***MEDICAL*** insurance.

Should you ***change*** insurance carriers while in active treatment in my office, we have no way of knowing this fact. The HMO **does not inform me** of the changes, as you would expect. If you come in for an office visit and we so not have a valid preauthorization for the visit ***from your new carrier***, you will be required to pay for that visit in full at the time of service.

For this reason, we ask that ***you immediately inform*** our office of any changes in your insurance status and give us a copy of your insurance card prior to coming in for your next appointment to get prior authorization. ***It is too late if you notify us the day of your appointment***.

I have read the above statement. By signing, I acknowledge that I will be responsible for any unpaid balances not covered by my insurance company.

Print Patient's Name	Patient's Signature	Date

IVAN LAPIDUS, D.D.S., INC.

Periodontics / Dental Implants
Orofacial Pain & Dysfunction

1964 WESTWOOD BOULEVARD
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LOS ANGELES, CALIFORNIA 90025

TELEPHONE (310) 446-4867
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Due to recent developments, we are asking all patients to answer the following:

Yes / No Are you allergic to Latex?

Yes / No Have you ever taken prescription medication for weight reduction (DIET PILLS)?
If "YES", did you take any of the Drugs listed below?
(please indicate with an X on the line.)

_____Fen-Phen (fenfluramine-phentemine)
_____Pondimin (fenfluramine)
_____Redux (dexfenfluramine)

Yes / No If you have ever taken any of the above drugs, have you had a medical Exam to insure that your heart valves were not affected?

Patient's Signature_____

Date_____

Please print name_____

Thank you for your time in completing the much needed information.

Sincerely,

Ivan Lapidus, D.D.S., Inc.

PAIN-PROBLEM QUESTIONNAIRE

Name_____ Date_____

1. Please give us the first time you noticed a problem with your jaw, head or neck pain.

   State approximate month and year._____

2. List in order of importance all of the problems or symptoms which trouble you. Be as brief as possible describing them.

3. Have you received any prior treatment or evaluation for this problem? describe briefly.

Doctor:	Treatment(s):	Results:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

(use back side if necessary)

4. Have you had a jaw, head or neck injury that could have caused your pain/problem?

   yes____no____

   If yes, please list the date of the injury(s) and describe.

5. If yes, please rate how much your jaw, head or neck injury contributed to the cause of your pain/problem. Please circle the appropriate number below.

   0 1 2 3 4 5 6 7 8 9 10

   _____

   No relationship — Main cause of Pain problem

6. Are you receiving any compensation or disability for your pain problem?

   Yes____No____

7. Are you currently in the process of litigation related to you pain problem?

   Yes____No____

   If yes, describe status of litigation_____

PAIN-PROBLEM QUESTIONNAIRE (Continued)

Name_____ Date_____

8. Rate how much pain you are experiencing right now at this moment by placing a slash (/) somewhere on the line below.

No pain _____ The most intense pain imaginable

9. Place 3 slash (/) marks on the line below to indicate the intensity of you pain at its (1) highest intensity, (2) usual intensity, and (3) lowest intensity over the last five days.

No pain _____ The most intense pain imaginable

10. Place 3 slash (/) marks on the line below to indicate your mood at its (1) best, (2) average, and (3) worst over the last 5 days.

Extremely good mood _____ Extremely bad mood

11. Rate how much has your pain stopped you from doing what you wanted to do over the last 5 days by placing a slash (/) somewhere on the line below.

Did not stop at all _____ Completely stopped me

12. Rate how much your pain/problem interferes with your jaw function (chewing, eating, etc.) by placing a slash (/) somewhere on the line below.

No problem _____ Extensive problem

13. Rate the quality of rest you have been getting over the past (5) days by placing a slash (/) somewhere on the line below.

Excellent rest _____ Very poor rest

PAIN-PROBLEM QUESTIONNAIRE (Continued)

Name_____ Date_____

14. Time of pain. Rate the usual intensity of your pain with a slash (/) along the scales below at the following periods throughout the day:

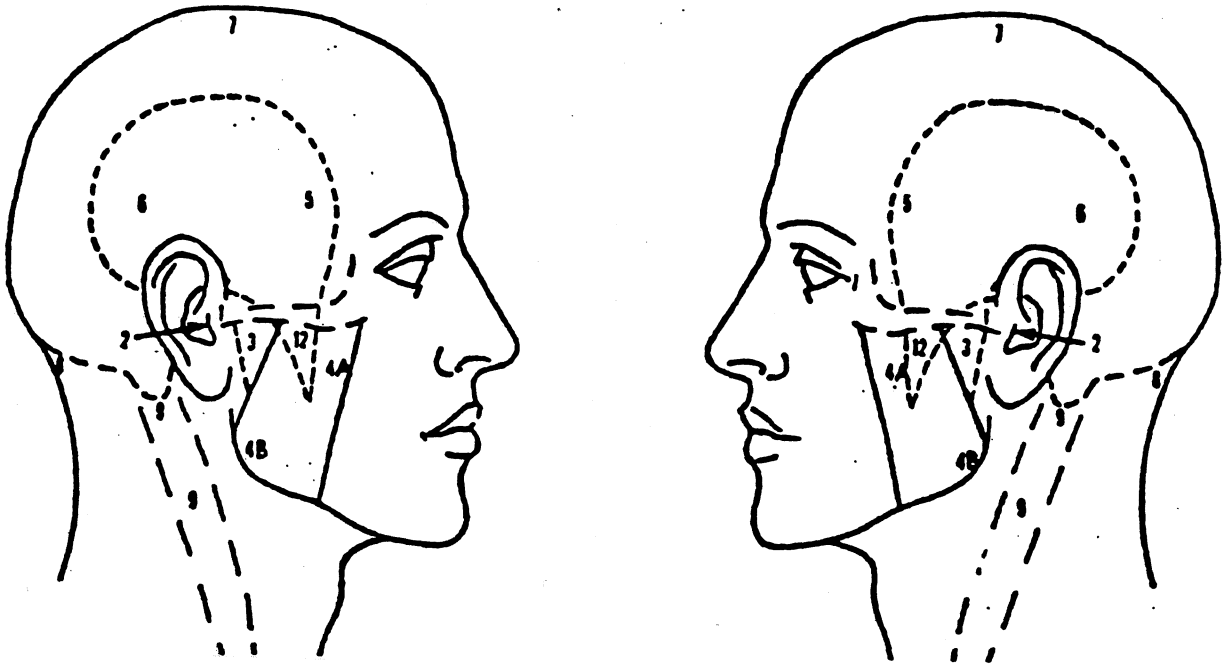
TIME

	No pain	The most intense pain imaginable
Morning	_____	
Noon	_____	
Afternoon	_____	
Evenings	_____	
Sleep	_____	

15. On the diagram below, please draw a circle around the areas in both head and neck where you currently have pain.

YOUR RIGHT SIDE

YOUR LEFT SIDE



JAW SYMPTOM AND ORAL QUESTIONNAIRE

Name_____ Date_____

INSTRUCTIONS: Please check the appropriate answer to the following questions.

Jaw Pain Questions	Doesn't Hurt At All	Hurts a Little	Hurts a Lot	Almost Unbear-able	Unbearable Pain Without Relief
1. Does it hurt when you open wide or yawn?	___	___	___	___	___
2. Does it hurt when you chew or use your jaws?	___	___	___	___	___
3. Does it hurt when not chewing or using the jaws?	___	___	___	___	___
4. Is your pain worse on walking?	___	___	___	___	___
5. Do you have pain in front of the ears or ear aches?	___	___	___	___	___
6. Do you have jaw muscle (cheek) pain?	___	___	___	___	___
7. Do you have pain in the temple?	___	___	___	___	___
8. Do you have pain or soreness in the teeth?	___	___	___	___	___

JAW FUNCTION QUESTIONS	No	Maybe a Little	Quite a Lot	Almost all the Time	All the time Without Stopping
1. Do your jaw joints make noise, so it bothers you and others?	___	___	___	___	___
2. Do you find it difficult to open your mouth wide?	___	___	___	___	___
3. Does your jaw ever lock closed so you cannot close it?	___	___	___	___	___
4. Does your jaw ever lock open so you cannot open it?	___	___	___	___	___
5. Do you have a problem with your bite being uncomfortable?	___	___	___	___	___

JAW HABITS QUESTIONS	No	Maybe a Little	Quite a Lot	Almost all the Time	All the time Without Stopping
1. Do you clamp or set your teeth during the day?	___	___	___	___	___
2. Do you clench or grind your teeth during sleep?	___	___	___	___	___
3. Do you hold tension in your jaw or facial muscles?	___	___	___	___	___
4. Do you chew exclusively on one side?	___	___	___	___	___
5. Do you chew gum frequently?	___	___	___	___	___

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare#) MEDICAID ☐ (Medicaid#) TRICARE ☐ (ID#/DoD#) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (ID#) FECA BLK LUNG ☐ (ID#) OTHER ☐ (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. RESERVED FOR NUCC USE

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) ☐ YES ☐ NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? ☐ YES ☐ NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

X SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

X SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1									NPI	
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

Ivan L. Lapidus, D.D.S., Inc.
1964 Westwood Blvd., Suite 200
Los Angeles, CA 90025
(310) 446-4867

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to sign This Acknowledge

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
Date

For Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgment
- ☐ An emergency situation prevented us from obtaining acknowledgment
- ☐ Other (Please Specify)

_____

_____

_____

This Form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002)

Ivan L. Lapidus, D.D.S., Inc. 1964 Westwood Blvd. Suite 200 Los Angeles, CA 90025 (310) 446-4867

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required to applicable federal and state law to maintain the privacy of your health information. We are also required to give this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect **April 14, 2003**, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURE OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you. We will assist you in obtaining your insurance benefits; however, you are ultimately responsible for payment.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment, or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you gives us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason expect those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your

healthcare, not only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosures of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgement disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, e-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

Appointments are reserved for you. **48** hour notice must be given, if a cancellation is necessary. In the event of a cancellation without **48** hours notice, charges will apply.

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you **$0.10** for each page, **$20.00** per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-bases fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before **April 14, 2003.** If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure

of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. However, you must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be emended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS
If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Jessie Creecy

Telephone: (310) 446-4867

Fax: (310) 446-4715

E-mail: N/A

Address: 1964 Westwood Blvd. Suite 200
Los Angeles, CA 90025

This form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002).