Synovation MEDICAL GROUP **NEW PATIENT REGISTRATION**

Patient Name:		**DOB:**		**Sex:**	
		DL/ID#:		**Race:**	
E-mail:		**SSN:**		**Ethnicity:**	
Mailing Address:				**Marital Stat:**	
Pref. Language:		**Phone:**		☐ **Home/**☐ **Mobile/**☐ **Work**	

☐ I need interpreter services.	☐ I prefer to use my adult companion as an interpreter.
☐ أحتاج إلى خدمات الترجمة.	☐ أفضل استخدام رفيقي البالغ كمترجم فوري.
☐ Ինձ հարկավոր է թարգմանչական ծառայություններ:	☐ Ես նախընտրում եմ օգտագործել իմ մեծահասակ ուղեկիցը որպես թարգմանիչ:
☐ 我需要口译服务。	☐ 我更喜欢用我的成年伴侣作为口译员。
☐ मुझे दुभाषिया सेवाओं की आवश्यकता है।	☐ मैं एक दुभाषिया के रूप में अपने वयस्क साथी का उपयोग करना पसंद करता हूं।
☐ Kuv xav tau neeg txhais lus.	☐ Kuv nyiam siv kuv tus txwj laus ua tus txhais lus.
☐ 通訳サービスが必要です。	☐ 私は大人の仲間を通訳として使うことを好みます。
☐통역 서비스가 필요합니다.	☐ 나는 성인 동반자를 통역사로 사용하는 것을 선호합니다.
☐ ខ្ញុំត្រូវការសេវាកម្មអ្នកបកប្រែភាសា។	☐ ខ្ញុំចូលចិត្តប្រើដៃគូពេញវ័យរបស់ខ្ញុំជាអ្នកបកប្រែភាសា។
☐ من به خدمات مترجم نیاز دارم.	☐ من ترجیح می دهم از همراه بزرگترم به عنوان مترجم استفاده کنم.
☐ ਮੈਨੂੰ ਦੁਭਾਸ਼ੀਏ ਸੇਵਾਵਾਂ ਦੀ ਜਰੂਰਤ ਹੈ.	☐ ਮੈਂ ਆਪਣੇ ਬਾਲਗ ਸਾਥੀ ਨੂੰ ਦੁਭਾਸ਼ੀਏ ਵਜੋਂ ਵਰਤਣਾ ਪਸੰਦ ਕਰਦਾ ਹਾਂ
☐ Мне нужны услуги переводчика.	☐ Я предпочитаю использовать своего взрослого спутника в качестве переводчика.
☐ Necesito servicios de intérprete.	☐ Prefiero utilizar a mi compañero adulto como intérprete.
☐ Kailangan ko ng serbisyo ng tagapagsalin.	☐ Mas gusto kong gamitin ang aking kasamang nasa hustong gulang bilang tagasalin.
☐ ฉันต้องการบริการล่าม	☐ ฉันชอบใช้คู่หูผู้ใหญ่เป็นล่าม
☐ Tôi cần dịch vụ phiên dịch.	☐ Tôi thích sử dụng người bạn đồng hành của tôi như một thông dịch viên.

Occupation:		**Employer Name:**			
Employer Ph:		**Employer Address:**			
Primary Ins:		**Group #:**		**Policy #:**	
2nd Ins:		**Group #:**		**Policy #:**	

CONSENT TO TREATMENT AND TELEHEALTH	**Initials**
The undersigned patient, or agent on behalf of the patient, (i) consents to the patient's evaluation and treatment by Synovation Medical Group Texas, PLLC ("SMG") and SMG's providers; and (ii) authorizes the same to consult and engage any other provider as necessary if any surgical procedure is to be performed.	
The undersigned patient or agent understands that (i) SMG sponsors a fellowship program in pain management; and (ii) the patient may receive treatment from fellows unless SMG is notified in writing of a desire for nonparticipation.	
The undersigned patient or agent (i) understands that (a) telehealth is the use of audio or audiovisual communication and/or information technologies to remotely deliver healthcare services, (b) the patient's image or information may be accessible to the entity providing the telehealth platform, (c) the patient has the right to access covered services that may be delivered via telehealth through an in person visit, (d) the use of telehealth is voluntary and may be discontinued at any time without affecting the patient's ability to access covered services, (e) certain insurances may cover transportation to in-person visits when other available resources have been reasonably exhausted, and (f) the risks and limitations of telehealth include security failures that compromise confidentiality and treatment without in person interaction; and (ii) having their questions (if any) answered to their satisfaction, consent to the patient's receipt of telehealth services.	

DOES THE PATIENT HAVE AN ADVANCE HEALTH CARE DIRECTIVE (a "Directive")?
☐ **YES** and a copy ☐ is with the patient's primary care physician ("PCP") and/or ☐ will be provided to SMG; OR
☐ **NO** but the patient will ☐ discuss it with the patient's PCP and ☐ provide SMG with a copy of the Directive.

INTEREST DISCLOSURE STATEMENT
An SMG provider may refer the patient to an organization (i) in which SMG or the provider has a financial or beneficial interest (ex. ownership); or (ii) with whom SMG or the provider has a personal services arrangement (ex. directorship). An owner, employee, or contractor of SMG may order the performance of laboratory work by SMG's centralized laboratory or physical or occupational therapy by an SMG employee or the provision of surgical facilities by an SMG affiliate. The patient may choose any organization or person (who is not necessarily employed by SMG) to provide any service that an SMG provider orders or prescribes. Nothing herein shall be interpreted as a guarantee that any service will be authorized, no cost, or covered by insurance. If you wish to file a complaint in connection with this interest disclosure statement, you may contact your state's medical board.

ASSIGNMENT OF INSURANCE BENEFITS	Initials
The undersigned patient, or agent on behalf of the patient, (i) irrevocably assigns to SMG all of the patient's rights and benefits under the patient's insurance contract, policy, and/or plan for payment for services rendered to the patient at/by SMG, including, but not limited to, the right to litigate under the civil remedies provision of the Employment Retirement Income Security Act and, if any plan or insurer refuses to recognize the foregoing assignment of benefits, the right to file a lawsuit in the patient's name; (ii) authorizes SMG to file insurance claims on the patient's behalf for services rendered to the patient at/by SMG and to release any information necessary for processing applications for financial benefit; and (iii) authorizes the direct payment of benefits to SMG.	
The undersigned patient, or agent on behalf of the patient, (i) agrees to pay for all services rendered to patient at/by SMG; and (ii) agrees to pay reasonable attorney's fees and costs should legal proceedings be necessary to collect any portion of the patient's bill or to enforce this agreement.	
The undersigned patient or agent (i) consents to communications regarding the patient's healthcare, appointments, and unpaid bills; (ii) agrees that such communication may include emails, calls, and text or voice messages (including prerecorded messages), contain confidential information, involve charges by phone service providers, and be generated by an automated dialing system or an automatic telephone dialing system; (iii) understands that SMG will not encrypt, and cannot guarantee the security of, electronic communication; and (iv) agrees that SMG is not responsible for any unauthorized access via a device or account associated with the phone number or email address provided above.	

AGREEMENT
The undersigned patient or agent (i) represents and warrants that the information herein is true and correct and agrees to notify SMG of any change thereto; (ii) agrees to the terms hereof and of EXHIBIT A Policies & Procedures and EXHIBIT B Patient & Companion Code of Conduct attached hereto and incorporated by reference herein; and (iii) acknowledges receipt of EXHIBIT C Notice of Language Assistance Services.

Patient's Signature:		Date:	
Name of ☐ Interpreter* or ☐ Agent (pls provide copy of POA):		Signature:	
Relationship to Patient:		Date:	

* The above-signed interpreter represents that the interpreter is at least 18 years of age and agrees to interpret for the patient and to communicate any need (due to emotionality, complexity) or desire for another interpreter.

Witness Signature (if signatory above signs with a mark/"X"):		Name of Witness:	
		Date:	
Witness Signature (if signatory above signs with a mark/"X"):		Name of Witness:	
		Date:	

Synovation MEDICAL GROUP **NEW PATIENT REGISTRATION**

General Health History (Please complete with the patient as "you" or "your")

Patient Name:				*Date of Birth:*		*Sex (assigned at birth):*	☐M/☐F
Age:		*Height:*		*Weight:*		*Yrs Worked:*	

1. *Do you have a problem with any of the following?* ☐ *Heart* ☐ *Lungs* ☐ *Liver*
   ☐ *Kidneys* ☐ *Stomach/Ulcer* ☐ *Stroke* ☐ *Diabetes* ☐ *High Blood Pressure*
   ☐ *Other Health Conditions:* _____
2. *List all surgeries you've had (w/ dates):* _____
3. *List all your current medications w/ frequencies & dosages (or attach a medication list):*

Medication	*Frequency*	*Dosage*	*Medication*	*Frequency*	*Dosage*

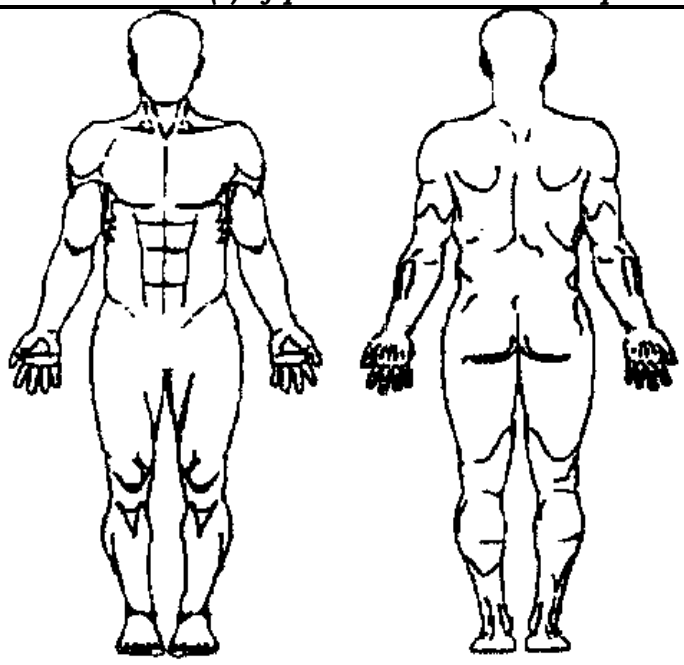
4. *List all allergies:* _____ ☐ *None/NKA*

Pain History (Please complete with the patient as "you" or "your")

1. *Do you have any of the following symptoms?*

☐ *Headache*	☐ *Dizziness*	☐ *Vision Problems*
☐ *Hearing Problems*	☐ *Neck Pain*	☐ *Shortness of Breath*
☐ *Chest Pain*	☐ *Cough*	☐ *Nausea*
☐ *Vomiting*	☐ *Diarrhea*	☐ *Constipation*
☐ *Blood in Stool*	☐ *Dark Tarry Stool*	☐ *Abdominal Pain*
☐ *Pelvic Pain*	☐ *Pain on Urination*	☐ *Urinary Problems*
☐ *Rash*	☐ *Itching*	☐ *Tender Muscles*
☐ *Back Pain*	☐ *Stiff Joints*	☐ *Swollen Joints*
☐ *Loss of Balance*	☐ *Weakness of Limbs*	☐ *Numbness of Hand*
☐ *Numbness of Arm*	☐ *Numbness of Leg*	☐ *Numbness of Feet*
☐ *Fever*	☐ *Chills*	☐ *Poor Sleep*
☐ *Weight Loss*	☐ *Weight Gain*	
☐ *Other Symptoms:*		

Mark area(s) of pain and describe the pain:



Pain Area:	
Pain Level:	☐*0 (None)* ☐*1* ☐*2* ☐*3* ☐*4* ☐*5* ☐*6* ☐*7* ☐*8* ☐*9* ☐*10 (Worst Imaginable)*
Pain Description:	☐ *Constant* ☐ *Intermittent* ☐ *Throbbing* ☐ *Stabbing* ☐ *Sharp* ☐ *Dull* ☐ *Shooting* ☐ *Burning*

2. *When did your pain start?* _____

3. *How did your pain start?* _____

4. *What aggravates your pain?* _____

5. *What relieves your pain?* _____

6. *Did you have similar pain problems before your current one?* ☐ *Yes* ☐ *No*

   If yes, please explain: _____

7. *Have you had tests done?* ☐ *MRI* ☐ *CT Scan*
   ☐ *X-Ray* ☐ *Bone Scan* ☐ *EMG* ☐ *Other:* _____

8. *Have you had any treatment for your pain?* ☐ *Medications* ☐ *Epidural Injections* ☐ *TENS Unit*
   ☐ *Nerve Blocks* ☐ *Physical Therapy* ☐ *Acupuncture* ☐ *Other:* _____

9. *List all other medications tried previously for your pain:* _____

Psychological History and Substance Use (Please complete with the patient as "you" or "your")

1. *Does your pain cause you to suffer any of the following?* ☐ *Frustration* ☐ *Anxiety* ☐ *Depression*
   ☐ *Insomnia/Sleeplessness* ☐ *Suicidal Thoughts--when was the last time?*_____;
   have you ever attempted suicide? ☐ *Yes* ☐ *No*
2. *How is the stress in your life?* ☐ *Below Average* ☐ *Average* ☐ *Above Average*
3. *Do you now see or have you ever seen a psychiatrist/psychologist?* ☐ *Yes* ☐ *No*
4. *Do you smoke tobacco?* ☐ *Yes, freq.:*_____ ☐ *No* ☐ *Quit* _____ *yrs. ago, freq.:* _____ *for* ___ *yrs.*
5. *Do you use alcohol?* ☐ *Yes, freq.:*_____ ☐ *No* ☐ *Quit* _____ *yrs. ago, freq.:* _____ *for* ___ *yrs.*
   Types: ☐ *Beer* ☐ *Wine* ☐ *Other:* _____
6. *Do you use illicit drugs?* ☐ *Yes, freq.:*_____ ☐ *No* ☐ *Quit* _____ *yrs. ago, freq.:* _____ *for* ___ *yrs.*
   Types: ☐ *Cocaine* ☐ *Heroin* ☐ *Other:* _____

Miscellaneous

1. *Are you receiving any of the following benefits?* ☐ *Disability* ☐ *Workers' Compensation* ☐ *NA*
2. *Are you currently involved in any legal action or proceeding?* ☐ *Yes* ☐ *No*

   If yes, please explain: _____

Additional Comments:	

Consent and Authorization to Use and Disclose Information

CONSENT TO USE AND DISCLOSURE OF PHI FOR TPO. The undersigned understands that, as part of patient's healthcare, SMG originates and maintains paper and/or electronic records describing patient's health history, symptoms, examination and test results, diagnoses, treatment, any plan for future care or treatment, and other information relating to patient's healthcare—which serves as (i) a basis for planning patient care and treatment; (ii) a means of communication among the health professionals contributing to patient's care; (iii) a source of information for applying patient's information to patient's bill; (iv) a means by which a third-party payer can verify the services provided; and (v) a tool for healthcare operations such as assessing quality and staff competence. The undersigned understand that, as part of SMG's treatment, payment, and healthcare operations ("TPO"), it may be necessary to disclose patient's health information to another person or entity. Therefore, the undersigned patient or agent, for himself/herself or the patient, consents to the foregoing uses and disclosures, including disclosures in electronic format. The undersigned acknowledges receipt of the Joint Notice of Privacy Practices attached hereto as EXHIBIT D and incorporated herein by reference (the "Notice"), which provides a description of the uses and disclosures of patient's protected health information ("PHI"). The undersigned understands (i) the rights and privileges described on the Notice; (ii) that SMG reserves the right to change the content of the Notice and their privacy practices and to apply such changes to PHI that was created or received prior to the issuance of the revised Notice, in accordance with federal regulations; and (iii) that such revised Notice (if any) will be made available on SMG's website at www.synovationmedicalgroup.com, at SMG's office, and to the undersigned – upon request – by ☐ **mail** / ☐ **electronic transmission**. The undersigned wishes to have the following restrictions on the use and/or disclosure of patient's information: _____.

The undersigned understands that (i) SMG is not required to agree to the requested restrictions, except as specified on the Notice; (ii) the undersigned may revoke this consent in writing, except to the extent that SMG has already taken action in reliance thereon; and (iii) by refusing to give consent or revoking this consent, SMG may refuse to treat patient as permitted by federal regulations. The undersigned fully understands and ☐ **accepts** / ☐ **declines the terms of this consent**.

Signature:		Date:	
Name:		Relationship to Patient:	

AUTHORIZATION TO COMMUNICATE. The undersigned authorizes SMG, patient's healthcare provider, to communicate with the following about the patient's healthcare, payment information, and appointments until the earlier of _____ or 10 years after the signature date below. The undersigned understands that (i) this authorization may be prospectively revoked on written notice to SMG; (ii) the following may redisclose patient's information (without further protection by privacy laws); (iii) executing this authorization is not a condition of patient's treatment; and (iv) the undersigned has the right to receive a copy of this form.

Name	**Rel. to Pt.**	**Postal/E-mail Address**	**Phone#**	☐ **for emergencies only**

Signature:		Date:	
Name:		Relationship to Patient:	

EXHIBIT A (to New Patient Packet): Policies & Procedures

TO OUR NEW PATIENTS, welcome to Synovation Medical Group Texas, PLLC. To better serve our patients, we have adopted the following policies and procedures:

1. **PLEASE BRING THE FOLLOWING ITEMS ON YOUR FIRST APPOINTMENT**: (i) *picture ID card;* (ii) *insurance card;* (iii) *authorization form; and* (iv) *for those patients who are seeing a physician, the patient's (a) medication list (or bottles), (b) x-ray imaging reports, and (c) other medical records.*
2. **YOU MUST COMPLETE THE REGISTRATION PAPERWORK BEFORE SEEING A PROVIDER**. Please arrive 45 minutes early if you have not completed the paperwork, 15 minutes early if you have.
3. **PLEASE BE ON TIME**. If you are late for your appointment, you may have to reschedule your appointment. Patients who fail to cancel an appointment within 24 hours of the appointment time may be subject to a $50.00 fee billed directly to the patient (subject to applicable Medicaid restrictions).
4. **YOU MUST SHOW YOUR INSURANCE CARD AT EACH VISIT**. We will bill most insurance companies for our patients as a courtesy, provided we have all the necessary information. It is your responsibility to verify with the carrier as to whether the medical services provided to you/the patient are covered by your/the patient's insurance. Any deductible, copayment, or balance not paid by a patient's insurance is the patient's financial responsibility. This applies to all insurances, including Medicare.
5. **CO-PAYMENTS AND DEDUCTIBLES ARE DUE WHEN SERVICES ARE RENDERED**. If a patient does not have or is unable to pay the patient's copayment at the time of the patient's appointment, the patient will have to reschedule the appointment until such time as the patient can pay it. We are sorry, but there can be no exception. Insured patients are responsible for all charges not paid by their insurance within 45 days after the date of service. Payment arrangements can be made on an individual basis at our discretion. We do not accept checks marked with "Payment in Full" or words of similar meaning when the amount of the check is less than the amount charged to the patient. Any deposit of such a check is inadvertent, is not a satisfaction of the full amount owed by the patient, and will be considered a partial payment. We reserve the right to withdraw the extension of credit. There is a service fee of $20 on all returned checks.
6. **DISCLOSURE OF INFORMATION**. Disclosure of insurance and other information is necessary for services received to be paid in full. If the patient's ailment or injury is due to any type of personal injury, accident, or malicious conduct for which the patient is seeking damages, you/the patient must notify us and sign a lien in our favor. Your failure to make necessary disclosures might make the patient personally responsible for all charges incurred by the patient for services rendered by us.

Thank you for taking the time to read this material. Your cooperation is much appreciated.

EXHIBIT B (to New Patient Packet): Patient & Companion Code of Conduct

Synovation Medical Group Texas, PLLC ("SMG") is committed to providing a safe and inclusive environment of care. This Patient & Companion Code of Conduct has been established to provide patients and their companions with a non-exhaustive list of expectations when at an SMG facility.

APPOINTMENTS AND TREATMENT: Patients are expected to arrive on time for their appointment, provide 24 hours' notice of any cancellation, and comply with their treatment plan.

BEHAVIOR: Abusive or offensive behavior—including harassment, the use of derogatory language, and discrimination based on protected characteristics (ex. race, religion, gender, age, disability)—is unacceptable.

IMBIBING AND SMOKING: Consuming (or possessing open containers of) alcoholic beverages is prohibited. Smoking on premises is prohibited.

INFECTION CONTROL: Patients and companions must follow posted infection control instructions as well as instructions from SMG staff.

LITTERING: All trash must be disposed of in designated receptacles.

NOISE: Patients and companions must respect the peace of others and keep noise to a minimum.

PARKING AND PERSONAL PROPERTY: Vehicle drivers must comply with parking regulations. Violators may be cited and/or have their vehicles towed at their expense. Patients and companions must not leave their property unattended. Belongings are left unattended at owner's risk. SMG shall not be liable for the loss of, or damage to, vehicles and property.

PETS: Pets are not allowed on premises, but a service animal (such as a guide/signal/service dog or miniature horse) that is under control, housebroken, and trained or (under conditions provided by applicable law) in training to perform work for a person with disability is allowed on premises.

RECORDING: Taking photographs and/or recordings of SMG staff and/or patients without permission is strictly prohibited.

SOLICITATION: Solicitation without approval from SMG staff is prohibited.

▶**VANDALISM AND THEFT**: Theft and intentional damage or defacement of SMG property will not be tolerated.

▶**VIOLENCE:** Threats or acts of physical violence directed at SMG staff, patients, and companions will not be tolerated.

▶**CONTRABAND**: Illicit drugs and other contraband are strictly prohibited.

To the extent appropriate and practicable, a patient or companion suspected of noncompliance will be given the opportunity to provide an explanation. Reasonable accommodations may be provided. A noncompliant patient may be asked to leave the premises and may be discharged from SMG's care, subject to applicable continuity of care standards. A noncompliant companion may be asked to leave the premises and have their return to any SMG facility conditioned, restricted, or prohibited. SMG reserves the right to prosecute any red flag (▶) violation to the full extent of the law.

224 N. Fair Oaks Avenue Suite 300 Pasadena, CA 91103
Phone: (800)807-3422 • Fax: (626)696-1450 • E-mail: info@synovationmedicalgroup.com

EXHIBIT C (to New Patient Packet): Notice of Language Assistance Services

ATTN: If you speak a language other than English, language assistance services, free of charge, are available to you.

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان.

ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ:

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं।

LUS CEEV: Yog tias koj hais lus Hoo, cov kev pab txog lus, muaj kev pab dawb rau koj.

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد.

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ।

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad.

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn.

Discrimination is Against the Law

Synovation Medical Group Texas, PLLC ("SMG") complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. SMG does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. SMG provides access to the following:

• Free aids and services to people with disabilities to communicate effectively with us, such as (i) qualified sign language interpreters and (ii) written information in other formats (large print, audio, accessible electronic formats, other formats); and

• Free language services to people whose primary language is not English, such as (i) qualified interpreters and (ii) information written in other languages.

If you need these services, call us at 1-800-807-3422 or ask one of our office managers.

If you believe that SMG has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with one of our office managers. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our office managers are available to help you. To find one of our office locations, please visit http://synovationmedicalgroup.com/locations/.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW, Room 509F, HHH Building Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at https://www.hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html.

EXHIBIT D (to New Patient Packet):
JOINT NOTICE OF PRIVACY PRACTICES

HIPAA Privacy & Security Officer: (626)696-1413 (ph.); 224 N. Fair Oaks Ave. Ste. 300 Pasadena, CA 91103
Medical Records: (909)493-3800 (ph.); 10565 Civic Center Dr. Ste. 250 Rancho Cucamonga, CA 91730

Effective Date: 11-16-2023

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**.

Our Responsibilities. We are required by the Health Insurance Portability and Accountability Act ("HIPAA") and other applicable laws to maintain the privacy and security of your Protected Health Information ("PHI"). We will promptly inform you if a breach occurs that may have compromised the privacy or security of your PHI. We must follow the duties and privacy practices described in, and give you a copy of, this notice. We will not use or disclose your information other than as described here unless you authorize us in writing. For more information, please visit https://www.hhs.gov/hipaa/for-professionals/index.html.

Our Uses and Disclosures. We typically use or disclose your health information in the following ways:

1. Treatment. We may use your PHI and disclose it to other healthcare providers who are treating you. For example, a specialist physician treating you may provide your PHI to the referring primary care physician.

2. Payment. We may use and disclose your PHI to bill and get paid for our services. For example, we may give information about your treatment to your insurance to collect payment for the treatment.

3. Health Care Operations. We may use and disclose your PHI to run our practice or facility. For example, we may use your PHI to manage your care. We may contact you to remind you of an appointment or to inform you of treatment alternatives. PHI may be disclosed to our business associates if necessary for their services.

Our Other Uses and Disclosures. We are allowed—and may be required—to share your PHI in other ways. For more information, visit https://www.hhs.gov/hipaa/for-individuals/index.html.

1. Public Health and Safety. PHI may be shared as necessary to (i) help prevent or reduce a serious threat to anyone's health or safety (ii) prevent disease; (iii) report vital events; (iv) report suspected abuse, neglect, or domestic violence; (v) report adverse reactions to medications; and (vi) help with product recalls.

2. Research. PHI may be used and disclosed in the conduct of research studies that went through an approval process to ensure appropriate safeguards; however, prior to the approval process, researchers may be allowed to view limited data to identify patients who may be included in the study. After receiving approval, researchers may invite you to participate in the study. We may use a third-party electronic health record provider and participate in such provider's research network. The provider and its contractors may use de-identified patient information and aggregated data for purposes of research, public health, or health care operations or any purpose for which patient authorization is obtained.

3. Required by Law. PHI must be shared if required by federal or state law. PHI may be disclosed to a health oversight agency as authorized by law. The Department of Health and Human Services may require us to share your PHI to verify our compliance with federal privacy laws.

4. Organ and Tissue Donation. PHI of organ donors may be disclosed to organ procurement organizations.

5. Coroners, Medical Examiners, and Funeral Directors. PHI may be disclosed to a coroner, medical examiner, or funeral director as necessary for their duties.

6. Law Enforcement. PHI may be disclosed for law enforcement purposes or to a law enforcement official (ex. to report a crime on our premises) or as required or permitted by law or in compliance with a court order or a grand jury subpoena. If you are an inmate of a correctional institution or in the custody of a law enforcement officer, your PHI may be disclosed to the institution or the officer.

7. Special Government Functions. PHI may be disclosed to federal officials for (i) national security activities; and (ii) the protection of the President or other heads of state. If you are/were a member of the armed forces, your PHI may be disclosed to military authorities as permitted or required by law.

8. Workers' Compensation. PHI may be disclosed for workers' compensation claims.

9. Legal Actions. If you are involved in a lawsuit, PHI may be disclosed in response to (i) a subpoena or other lawful process by someone involved in the lawsuit, but only if efforts have been made to inform you of the request or obtain an order protecting the PHI requested; or (ii) a court or administrative order.

10. Transactions. PHI may be disclosed as part of a business transaction such as a merger or acquisition.

Your Choices. ***Unless you object, the following may receive your PHI***: (i) a family member, friend, or other person involved in your care or the payment for your care; and (ii) disaster relief organizations. If you are unable to tell us your preference (ex. you are unconscious), we may share your PHI 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 health or safety. We may contact you for fundraising efforts, but you can tell us not to contact you again. ***Except as otherwise permitted by law, the following require your written authorization***: (i) marketing; (iii) sale of your PHI; and (iii) most disclosures of psychotherapy notes. You may revoke your authorization at any time by written notice to us, but a revocation will not affect prior uses and disclosures.

Your Rights.

1. Right to Inspect and Copy. You have the right to inspect and receive a paper or electronic copy of your PHI—other than (i) psychotherapy notes; and (ii) information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding. You may ask our Medical Records Department how to do this. A copy or summary of your PHI will be made available within thirty (30) days (or fewer as required by state law) of your written request. We may charge you a reasonable, cost-based fee. A fee will not be charged if the PHI is needed to claim Social Security benefits or other state or federal needs-based benefits. Requests may be denied in certain circumstances, but you may have the denial reviewed except in circumstances designated by applicable law and/or regulation as unreviewable.

2. Right to Request an Amendment. To correct your PHI, you must send us a written request. Your request may be denied. You will be informed of the denial within sixty (60) days of your request.

3. Right to an Accounting of Disclosures. You have the right to request a list of times we disclosed your PHI except for treatment, payment, or operational disclosures and disclosures you authorized. The list can only go back six (6) years prior to the date of your request. To get such a list, you must send a written request to our Medical Records Department. We provide one (1) free accounting a year but charge a reasonable, cost-based fee for a list provided within twelve (12) months of a prior list.

4. Right to Request Confidential Communications. You may ask us to contact you in a specific way (ex. home or work phone) or to send mail to another address. We will accommodate all reasonable requests.

5. Right to Request Restrictions. You may ask us in writing to restrict the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to approve the request, and we may deny the request if it would affect your care. If you ask us to restrict the use and disclosure of your PHI to a health plan and such PHI pertains solely to a healthcare item or service for which you have paid out-of-pocket in full, we will comply with the restriction unless a law requires us to share the PHI.

6. Right to Representation. If you have a medical attorney-in-fact, legal guardian, or (if you are a minor) parent, such person can exercise your rights and make choices regarding your PHI. We verify any claim of authority to act on another's behalf.

7. Right to Complain. If you believe your right has been violated, you can file a complaint with (i) our HIPAA Privacy & Security Officer (*see* header); or (ii) the U.S. Department of Health and Human Services Office for Civil Rights at (877)696-6775, https://www.hhs.gov/hipaa/filing-a-complaint/index.html, or 200 Independence Ave., S.W. Washington, D.C. 20201. We will not retaliate against you for filing a complaint.

8. Right to a Paper Copy of this Notice. You may ask for a paper copy of this notice at any time, even if you agreed to receive this notice electronically. We will promptly provide you with a paper copy.

Changes to this Notice. We can change the terms of this notice, and the changes will apply to all PHI we have about you. The new notice will be posted in our office and on our website.

This Joint Notice of Privacy Practices applies to the following affiliated HIPAA-covered entities:	
Name and Service Area	Website
Algos, Inc., a Medical Corporation, dba Synovation Medical Group (CA)	www.synovationmedicalgroup.com
East Valley Pain Center, P.C., dba Synovation Medical Group (AZ)	www.synovationmedicalgroup.com
Synovation Medical Group, LLC, dba Synovation Medical Group (FL)	www.synovationmedicalgroup.com
Superior Pain Management, PC, dba Synovation Medical Group (SC)	www.synovationmedicalgroup.com
Synovation Medical Group Texas, PLLC (TX)	www.synovationmedicalgroup.com
Anesthesia Provider Group, Inc. (CA)	NA
Azusa Surgery Center LLC (Azusa, CA)	www.azusasurgerycenter.com
Mid Valley Surgery Center LLC (Ontario, CA)	www.midvalleysurgerycenter.com
Pasadena Surgery Center Inc. (Pasadena, CA)	www.thepasadenasurgerycenter.com
Stellar Surgical Specialties, Inc. (Rancho Mirage, CA)	www.stellarsurgery.com
Surgery Center of San Diego LLC (San Diego, CA)	www.surgerycenterofsandiego.com

NOTICE CONCERNING COMPLAINTS

Complaints about physicians, as well as other licensees and registrants of the Texas Medical Board, including physician assistants, acupuncturists, surgical assistants, medical radiologic technologists, non-certified radiologic technicians, respiratory care practitioners, medical physicists, and perfusionists may be reported for investigation at the following address:

Texas Medical Board
Attention: Investigations
1801 Congress Avenue, Suite 9.200
P.O. Box 2018
Austin, Texas 78768-2018

Assistance in filing a complaint is available by calling the following telephone number:

1-800-201-9353

For more information please visit our website at

www.tmb.state.tx.us