Hello and WELCOME to my office!!

HEALTH CARE PRACTITIONER INFORMATION
Name and License: Kwitka Durana Peratt, M.D.

Highest level of academic degree: Medical Doctor (M.D.)

Board Certification: Board Certified by the
American Board of Psychiatry and Neurology in Psychiatry and
Child and Adolescent Psychiatry

NOTICE TO PATIENTS
Medical doctors are licensed and regulated by the Medical Board of California. To check up on a license or to file a complaint go to
www.mbc.ca.gov,
email: licensecheck@mbc.ca.gov,
or call (800) 633-2322.

The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at
https://openpaymentsdata.cms.gov.

I have received these notices:

_____ _____
Patient name Guardian name

_____ _____
Guardian signature Date

OFFICE POLICIES/INFORMED CONSENT

General Consent For Treatment: The majority of individuals benefit from psychotropic medication and/or therapy, but results vary dependent on the conditions being treated. It is possible that a patient will not improve. While treatments are designed to be helpful, there is potential for disruption in the life of the patient and/or family while in treatment, and therapy can be emotionally painful. Your initial evaluation will include an explanation of your child's clinical symptoms, treatment plan, and estimated length of treatment. Benefits, as well as possible risks and side effects of each medication or other treatments, will be discussed. I authorize and request that Dr. Peratt carry out psychological examinations, diagnostic procedures and/or treatments which now or during the course of my child's care as a patient are advisable. If at any point any party feels it is not possible for us to work together for any reason, Dr. Peratt will do her best to refer you to other practitioners suitable for your needs. I understand that Dr. Peratt will keep a secure electronic or paper clinical record containing information regarding my diagnosis, treatment, prognosis and other documents pertinent to my treatment.

_____ (please initial)

Confidentiality: Information discussed during sessions and information recorded in the clinical record is considered confidential and will not be revealed without written authorization except as permitted by law. In certain circumstances, therapists are required by law to report suspicions of child abuse, elder abuse, and dependent adult abuse. Further, disclosure may be necessary if a client presents as a danger to himself or others, or where the client is gravely disabled. Disclosure may also be pursuant to a legal proceeding.

_____ (please initial)

Payment for Services: Clients are expected to pay for services at the time services are rendered. Fees for services include, but are not limited to:

New Patient evaluation (up to 90 minutes)	$600
Follow-up Appointments:	
45 – 55 minutes	$400
20 – 25 minutes	$250
Missed appointment/late cancellation (less than 48 hours notice)	Full Charge
Refills needed due to failure to make an appointment in time	$50
Emergency medication refill (needed same day, or over weekend/holiday)	$50
Legal fees (Any time spent by Dr. Peratt on legal matters including but not limited to preparation time, travel, and waiting time)	$20/minute
Reports/completion of forms billed at rate of time to complete. (Typically completed during sessions)	Appointment rate

***All fees are subject to change.

_____ (please initial)

Payment for Services continued:
I understand that **Dr. Peratt is not on any insurance panels** and that I am responsible for payment at each appointment. Accepted methods of payment include cash, credit card, debit card and checks. My account will be charged at the time services are rendered. I also understand that Dr. Peratt will provide me with a superbill for each visit indicating the services provided and that I may submit them to my insurance plan for reimbursement. I hereby assign Dr. Peratt all obtainable monies for services rendered. **It is my responsibility to contact my insurance company to find out exactly what mental health benefits are covered and to procure reimbursement from my insurance company if applicable.** I understand that I am responsible for charges not covered by my insurance assignment. Charges for missed appointments may not be eligible for reimbursement by insurance companies. If my account has payment overdue for over 60 days, legal means will be considered to secure payment. I further agree that in the event of non-payment, to bear the cost of my indebtedness along with any cost of collection, and/or court cost and reasonable legal fees should this be required.

_____ (please initial)

Appointment Cancellation: It is understandable that we may occasionally have difficulty keeping a scheduled appointment. Please note a minimum of forty-eight (48) hours' notice is required to cancel an appointment. Clients who fail to give forty-eight hours notice will be **charged their regular fee** for the appointment. The office does not call clients to remind them of scheduled appointments.

_____ (please initial)

Medication refills: Every effort will be made by Dr. Peratt to write a prescription that lasts until the next appointment. To promote safe and effective use of medications, if you are running out of medication please call Dr. Peratt, inform her of the need for more medication and the reason why. In some cases Dr. Peratt will be able to provide refills through your pharmacy after speaking with you. In case of a missed appointment or cancelled appointment Dr. Peratt may provide you with a small supply of medication to last until the rescheduled appointment.

_____ (please initial)

Emergency procedures: To contact your psychiatrist call **(949) 633-4464**. Dr. Peratt is the only person with access to the line and associated voicemail. Messages are typically checked several times per day, and all efforts are made to return phone calls by the end of the next business day. In the case of a life-threatening emergency that requires immediate assistance, dial 911.

_____ (please initial)

Absence from Care: Regular appointments are necessary to remain under the medical care of Dr. Peratt. Any patient who has a lapse in care of 90 days or more will be considered discharged from the clinic and no longer under the medical care of Dr. Peratt.

_____ (please initial)

I have read and understand these office policies and I agree to them.

_____ _____
Patient's Name (Please Print) Guardian name (Please Print)

_____ _____
Guardian Signature Date

HIPAA NOTICE OF PRIVACY PRACTICES
ACKNOWLEDGMENT OF RECEIPT

Privacy Officer: Kwitka Durana Peratt, M.D.
(949) 633-4464

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of any amended Notice of Privacy Practices will be available at each appointment.

☐ I would like to receive a copy of any amended Notice of Privacy Practices.

☐ I would NOT like to receive a copy of any amended Notice of Privacy Practices.

Signed: _____ Date:_____

Print Name: _____ Telephone:_____

If not signed by the patient, please indicate relationship:

☐ parent or guardian of minor patient

☐ guardian or conservator of an incompetent patient

Name and Address of Patient:

_____

_____

_____

PATIENT/GUARDIAN/PHYSICIAN PARTNERSHIP AGREEMENT

I understand and agree to the following:
In order to provide the best care for my child Dr. Peratt and I will need to work together. The goal of our partnership will be to maximize my child's health. In the spirit of this partnership Dr. Peratt asks me to promote my child's health in the following ways:

• **Keep follow up appointments and reschedule missed appointments and appointments I will not be able to make.** Following up as recommended allows Dr. Peratt to monitor my child's condition and my child's response to any treatments given. If an appointment is missed I run the risk that Dr. Peratt may not be able to adequately treat my child's condition, detect and minimize adverse effects and/or detect serious health conditions. In the event that I miss an appointment I will make my best effort to reschedule the appointment as soon as possible.

• **Keep Dr. Peratt informed of changes in my child's condition.** My child's condition may change between scheduled appointments or new information may come to light. It is important I keep Dr. Peratt informed of any symptoms my child develops that I find concerning so that Dr. Peratt can make the most accurate diagnosis and safest treatment recommendations. If I omit information I run the risk of my child receiving an erroneous diagnosis or suboptimal treatment, which could lead to serious health consequences.

• **Ask questions if I do not understand all details of my child's condition and treatment plan or need more information.** At times I may receive confusing information or information that provokes strong emotions at appointments. Dr. Peratt is happy to address any and all questions that will help me understand what is going on with my child and how I can best help my child.

• **Call the office when I do not hear the results of labs and other tests.** I understand Dr. Peratt's goal is to report my child's lab and test results to me as soon as possible. Typically results are discussed during follow up appointments. However, if I do not hear from Dr. Peratt regarding the status of results I will make sure to ask for the results.

• **Give medications to my child as prescribed.** Although it may be tempting, increasing, decreasing, suddenly stopping or otherwise changing medication may produce negative consequences. It is important Dr. Peratt be aware of any symptoms that would necessitate an adjustment to the treatment. If I feel there needs to be a change in a medication or other aspects of the treatment plan, I will contact Dr. Peratt (or in the case of an emergency utilize the advice of another appropriate physician such as an urgent care or emergency medicine physician).

• **Inform Dr. Peratt if I choose not to follow treatment recommendations.** After evaluation Dr. Peratt will make recommendations she feels are in the best interest of my child. These recommendations may include screening or diagnostic medical procedures (such as laboratory tests, imaging studies, etc.), medication, psychotherapy, referral to specialists (such as a primary care doctor, nutritionist, another therapist, or another medical specialist such as a neurologist or cardiologist) or even asking me to return to the office within a certain period of time. It is my right to consent to or refuse treatment. I understand not following the treatment plan can have serious negative effects on my child's health and wellbeing. I will let Dr. Peratt know if I decide not to follow a treatment recommendation so she may inform me of any risks associated with delaying or refusing treatment for my child. Dr. Peratt is happy to address any concerns I may have about my child's care.

Thank you for your partnership! As a guardian you have the right to be informed about the health care of your child. Dr. Peratt invites you to ask questions and discuss any concerns you have **at any time**.

_____
Patient Name

_____
Guardian Name

_____
Guardian Relationship to Patient

_____ _____
Guardian Signature Date

_____ _____
Kwitka Durana Peratt, M.D. Signature Date

PATIENT INFORMATION

Name_____ Nickname (if any)_____

DOB_____ Age_____ Sex_____ Race_____

Any complications during mother's pregnancy?_____
Born on time, early or late?_____
Vaginal or C-section birth?_____
Any complications with mother's delivery?_____
Any complications or special treatments after delivery?_____
Any developmental delays?_____

Has the child had any history of: (please circle)

Surgeries	Yes	No
Hospitalizations	Yes	No
Seizures	Yes	No
Head injury	Yes	No
Loss of consciousness	Yes	No
Meningitis/encephalitis	Yes	No
Broken bones	Yes	No
Diabetes	Yes	No
High Blood Pressure	Yes	No
High Cholesterol	Yes	No
Heart Disease	Yes	No
Thyroid disease	Yes	No
Asthma	Yes	No
Allergies	Yes	No

Any other health problems?_____
To your knowledge does your child use alcohol/drugs?_____
Any allergies to medications?_____
If yes, reaction_____

List current medications with dosage and time of day taken:

_____
_____
_____
_____

Approximate date of child's last physical:_____
Approximate date of child's last blood work:_____

Pediatrician/Primary Care Physician Name_____
Phone_____

Therapist Name_____
Phone_____

Has anyone on either side of child's family ever had: (please circle)

Anxiety, Depression, Bipolar Disorder, Schizophrenia/Psychosis,

ADD/ADHD, Learning difficulties, Autism, Attempted/Completed Suicide,

Drug/Alcohol Problem, Diabetes, High Blood Pressure, High Cholesterol,

Cancer, Seizure, Thyroid Problems, Heart Problems/Arrythmia, Sudden Death

Referral Source_____

Why have you brought your child to be seen?_____
_____
_____

Your child's strengths include:_____
_____
_____

Current school _____Grade _____
Ever held back?_____
Ever needed special education?_____
Ever had a 504 or IEP?_____
Ever had discipline issues at school?_____

Any concern for bullying/abuse?_____
Any legal issues?_____

Guardian #1
Name_____
Relationship To Patient_____

Guardian #2
Name_____
Relationship To Patient_____

Who currently has Legal custody of this child?_____

With whom does this child live?_____

Siblings:
Name _____Age _____Sex_____
Name _____Age _____Sex_____
Name _____Age _____Sex_____
Name _____Age _____Sex_____
Name _____Age _____Sex_____
Name _____Age _____Sex_____

Mother's Information:

Name_____SS#_____
Address_____
City_____State_____Zip_____
Phone (home)_____Can a message be left at this number? □ yes □ no
Phone (work)_____Can a message be left at this number? □ yes □ no
Phone (cell)_____Can a message be left at this number? □ yes □ no
How do you prefer to be contacted?_____
DOB_____Age_____Race_____Religion_____
Marital Status_____Spouse (if married)_____
Educational background_____
Occupation_____
Employer_____
Address_____

Father's Information:

Name_____SS#_____
Address (if different from above)_____
City_____State_____Zip_____
Phone (home)_____Can a message be left at this number? □ yes □ no
Phone (work)_____Can a message be left at this number? □ yes □ no
Phone (cell)_____Can a message be left at this number? □ yes □ no
How do you prefer to be contacted?_____
DOB_____Age_____Race_____Religion_____
Marital Status_____Spouse (if married)_____
Educational background_____
Occupation_____
Employer_____
Address_____

In case of Emergency Contact:
Name_____Relationship_____
Phone_____

Guardian Signature_____

Print Name _____Date_____

CREDIT CARD AUTHORIZATION

Dear Client:
If you have ever rented a car or hotel room you have been asked for a credit card at the time of booking, which is imprinted and may later be used to pay your bill. I have employed a similar policy. Your appointment is scheduled for you and in return you will be asked for a credit card number and the information will be held securely. This account can be used to pay for regular sessions or only for conditions listed below.

Payment is required for all services at the time they are rendered.

If you must cancel or reschedule an appointment, please do so at least 48 hours before the scheduled appointment time. You will be charged the full fee if you fail to show up for your appointments and do not notify my office 48 hours in advance.

Please note, your credit card will not be charged unless the following conditions apply:
no-show for a scheduled appointment,
cancellation less than 48 hours in advance, OR
participation in treatment (eg. appointment or phone session) without payment rendered.

Thank you for your cooperation.
Sincerely,
Kwitka Durana Peratt, M.D.

I, _____authorize Kwitka Durana Peratt, M.D. Inc., to charge my credit card if I fail to show for an appointment, for cancellations with less than 48-hour notice, and for any outstanding balance on my account. I will not dispute charges for sessions I have received or that I have not cancelled less than 48 hours in advance. I further authorize Dr. Peratt to disclose information about my attendance/cancellation to my credit card company if I dispute a charge.

credit card (circle one): Visa Mastercard Discover American Express

Last 4 digits of card _____

Expiration Date_____

Billing Zipcode_____

Name on card (please print)_____

Signature _____ Today's Date _____
(cardholder/financially responsible party)

Please note full card number and security code will be collected during the first appointment.

HIPAA Notice of Privacy Practices

Privacy Officer: Kwitka Durana Peratt, M.D. (949) 633-4464

Effective Date: 8-1-12

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.

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices with respect to protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our Privacy Officer listed above.

A. How This Medical Practice May Use or Disclose Your Health Information

This medical practice collects health information about you and stores it in a chart and on a computer. This is your medical record. The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

1. 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 also disclose medical information to members of your family or others who can help you when you are sick or injured.

2. 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 health care providers to assist them in obtaining payment for services they have provided to you.

3. Health Care Operations. We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of 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 and abuse detection and compliance programs and business planning and management. We may also share your medical information with our "business associates," such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them to protect the confidentiality and security of your medical information. Although federal law does not protect health information which is

disclosed to someone other than another healthcare provider, health plan or healthcare clearinghouse, 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 health care providers, health care clearinghouses 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 health care 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 and abuse detection and compliance efforts.

3. Appointment Reminders. 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.

5. Sign In Sheet. 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.

6. Notification and Communication With Family. 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 disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.

7. 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. If you are currently an enrollee of a health plan, we may receive payment for communications to you in conjunction with our provision, coordination, or management of your health care and related services, including our coordination or management of your health care with a third party, our consultation with other health care providers relating to your care, or if we refer you for health care, but only to the extent these communications describe: 1) a provider's participation in the health plan's network, 2) the extent of your covered benefits, or 3) concerning the availability of more cost-effective pharmaceuticals. We will not accept any payment for other marketing communications without your prior written authorization unless you have a chronic and seriously debilitating or life-threatening condition and we are making the communication in conjunction with our provision, coordination, or management of your health care and related services, including our coordination or management of your health care with a third party, our consultation with other health care providers relating to your care, or if we refer you for health care. If we make these types of communications to you while you have a chronic and seriously debilitating or life-threatening condition, we will tell you who is paying us, and we will also tell you how to stop these communications if you prefer not to receive them. We will not otherwise use or disclose your medical information for marketing purposes without your written authorization, and we will disclose whether we receive any payments for any marketing activity you authorize.

8. Required by Law. As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.

9. Public Health. We may, and are sometimes required by law to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.

10. Health Oversight Activities. We may, and are sometimes required by law to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by federal and California law.

11. Judicial and Administrative Proceedings. We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.

12. Law Enforcement. We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying of locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.

13. Coroners. We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.

14. Organ or Tissue Donation. We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.

15. Public Safety. We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

16. Specialized Government Functions. We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.

17. Worker's Compensation. We may disclose your health information as necessary to comply with worker's compensation laws. 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 occupational injury or occupational illness to the employer or workers' compensation insurer.

18. Change of Ownership. In the event that this medical practice is sold or merged with another organization, your health information/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.

19. Breach Notification. In the case of a breach of unsecured protected health information, we will notify you as required by law. If you have provided us with a current email address, we may use email to communicate information related to the breach. In some circumstances our business associate may provide the notification. We may also provide notification by other methods as appropriate.

B. When This Medical Practice May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, this medical practice will not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

C. Your Health Information Rights

1. Right to Request Special Privacy Protections. You have the right to request restrictions on certain uses and disclosures of your health information by a written request specifying what information you want to limit, and what limitations on our use or disclosure of that information you wish to have imposed. If you tell us not to disclose information to your commercial health plan concerning health care items or services for which you paid for in full out-of-pocket, we will abide by your request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any other request, and will notify you of our decision.

2. Right to Request Confidential Communications. You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular e-mail account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.

3. Right to Inspect and Copy. You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, 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 will charge a reasonable fee, as allowed by California and federal law. We may deny your request under limited circumstances. If we deny your request to access your child's records or the records of an incapacitated adult you are representing because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision. If we deny your request to access your psychotherapy notes, you will have the right to have them transferred to another mental health professional. If your written request clearly, conspicuously and specifically asks us to send you or some other person or entity an electronic copy of your medical record, and we do not deny the request as discussed above, we will send a copy of the electronic health record as you requested, and will charge you no more than what it cost us to respond to your request.

4. Right to Amend or Supplement. You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the

person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. You also have the right to request that we add to your record a statement of up to 250 words concerning any statement or item you believe to be incomplete or incorrect.

5. Right to an Accounting of Disclosures. You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 16 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.

6. You have a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by e-mail.

If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer listed at the top of this Notice of Privacy Practices.

D. Changes to this Notice of Privacy Practices

We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with this Notice. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and a copy will be available at each appointment.

E. Complaints

Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer listed at the top of this Notice of Privacy Practices.

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to:

Region IX
Office for Civil Rights
U.S. Department of Health & Human Services
90 7th Street, Suite 4-100
San Francisco, CA 94103
(415) 437-8310; (415) 437-8311 (TDD)
(415) 437-8329 FAX
OCRMail@hhs.gov

The complaint form may be found at www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaint.pdf. You will not be penalized for filing a complaint.

Contact Information:
Kwitka Durana Peratt, M.D.
6 Venture, Suite 350, Irvine, CA 92618
Phone: (949) 633-4464
Fax: (949) 682-3181

PRIVACY POLICY STATEMENT

Privacy Officer: Kwitka Durana Peratt, M.D. (949) 633-4464

Purpose: The following privacy policy is adopted to ensure that this Physician Practice complies fully with all federal and state privacy protection laws and regulations. Protection of patient privacy is of paramount importance to this organization. Violations of any of these provisions will result in severe disciplinary action including termination of employment and possible referral for criminal prosecution.

Effective Date: This policy is in effect as of 8-1-12.

It is the policy of this Physician Practice that we will adopt, maintain and comply with our Notice of Privacy Practices, which shall be consistent with HIPAA and California law.

Notice of Privacy Practices

It is the policy of this Physician Practice that a notice of privacy practices must be published, that this notice be provided to all subject individuals at the first patient encounter if possible, and that all uses and disclosures of protected health information be done in accord with this organization's notice of privacy practices. It is the policy of this Physician Practice to post the most current notice of privacy practices in our "waiting room" area, and to have copies available for distribution at our reception desk.

Assigning Privacy and Security Responsibilities

It is the policy of this Physician Practice that specific individuals within our workforce are assigned the responsibility of implementing and maintaining the HIPAA Privacy and Security Rules' requirements. Furthermore, it is the policy of this Physician Practice that these individuals will be provided sufficient resources and authority to fulfill their responsibilities. At a minimum it is the policy of this Physician Practice that there will be one individual or job description designated as the Privacy Official.

Deceased Individuals

It is the policy of this Physician Practice that privacy protections extend to information concerning deceased individuals.

Minimum Necessary Use and Disclosure of Protected Health Information

It is the policy of this Physician Practice that for all routine and recurring uses and disclosures of protected health information (PHI) (except for uses or disclosures made 1) for treatment purposes, 2) to or as authorized by the patient or 3) as required by law for HIPAA compliance) such uses and disclosures of PHI must be limited to the minimum amount of information needed to accomplish the purpose of the use or disclosure. It is also the policy of this Physician Practice that non-routine uses and disclosures will be handled pursuant to established criteria. It is also the policy of this organization that all requests for PHI (except as specified above) must be limited to the minimum amount of information needed to accomplish the purpose of the request, and where practicable, to the limited data set.

Marketing Activities

It is the policy of this Physician Practice that any uses or disclosures of protected health information for marketing activities will be done only after a valid authorization is in effect except as permitted by

law. It is the policy of this organization to consider any communication intended to induce the purchase or use of a product or service where an arrangement exists with a third party for such inducement in exchange for direct or indirect remuneration, or where this organization encourages purchase or use of a product or service directly to patients to constitute "marketing". This organization does not consider the communication of alternate forms of treatment, or the use of products and services in treatment, or a face-to-face communication made by us to the patient, or a promotional gift of nominal value given to the patient to be marketing, unless direct or indirect remuneration is received from a third party. Similarly, this organization does not consider communication to our patients who are health plan enrollees in conjunction with our provision, coordination, or management of their health care and related services, including our coordination or management of their health care with a third party, our consultation with other health care providers relating to their care, or if we refer them for health care to be marketing, but only to the extent these communications describe: 1) a provider's participation in the health plan's network, 2) the extent of their covered benefits, or 3) concerning the availability of more cost-effective pharmaceuticals. This organization may make remunerated communications tailored to individual patients with chronic and seriously debilitating or life-threatening conditions provided we are making the communication in conjunction with our provision, coordination, or management of their health care and related services, including our coordination or management of their health care with a third party, our consultation with other health care providers relating to their care, or if we refer them for health care. If we makes these types of communications to patients who have a chronic and seriously debilitating or life-threatening condition, we will disclose in at least 14-point type the fact that the communication is remunerated, the name of the party remunerating us, and the fact the patient may opt out of future remunerated communications by calling a toll-free number. This organization will stop any further remunerated communications within 30 days of receiving an opt-out request.

Mental Health Records

It is the policy of this Physician Practice to require an authorization for any use or disclosure of psychotherapy notes, as defined in the HIPAA regulations, except for treatment, payment or health care operations as follows:

A. Use by originator for treatment;

B. Use for training physicians or other mental health professionals as authorized by the regulations;

C. Use or disclosure in defense of a legal action brought by the individual whose records are at issue; and

D. Use or disclosures as required by law, or as authorized by law to enable health oversight agencies to oversee the originator of the psychotherapy notes.

Complaints

It is the policy of this Physician Practice that all complaints relating to the protection of health information be investigated and resolved in a timely fashion. Furthermore, it is the policy of this Physician Practice that all complaints will be addressed to [name or job title of person authorized to handle complaints] [(i.e. Privacy Official)] who is duly authorized to investigate complaints and implement resolutions if the complaint stems from a valid area of non-compliance with the HIPAA Privacy or Security Rule.

Prohibited Activities-No Retaliation or Intimidation

It is the policy of this Physician Practice that no employee or contractor may engage in any intimidating or retaliatory acts against persons who file complaints or otherwise exercise their rights under HIPAA regulations. It is also the policy of this organization that no employee or contractor may condition treatment, payment, enrollment or eligibility for benefits on the provision of an authorization to disclose protected health information except as expressly authorized under the regulations.

Responsibility

It is the policy of this Physician Practice that the responsibility for designing and implementing procedures to implement this policy lies with the Privacy Official.

Verification of Identity

It is the policy of this Physician Practice that the identity of all persons who request access to protected health information be verified before such access is granted.

Mitigation

It is the policy of this Physician Practice that the effects of any unauthorized use or disclosure of protected health information be mitigated to the extent possible.

Safeguards

It is the policy of this Physician Practice that appropriate safeguards will be in place to reasonably safeguard protected health information from any intentional or unintentional use or disclosure that is in violation of the HIPAA Privacy Rule. These safeguards will include physical protection of premises and PHI, technical protection of PHI maintained electronically and administrative protection of PHI. These safeguards will extend to the oral communication of PHI. These safeguards will extend to PHI that is removed from this organization.

Business Associates

It is the policy of this Physician Practice that business associates must comply with the HIPAA Privacy and Security Rules to the same extent as this Physician Practice, and that they be contractually bound to protect health information to the same degree as set forth in this policy pursuant to a written business associate agreement. It is also the policy of this organization that business associates who violate their agreement will be dealt with first by an attempt to correct the problem, and if that fails by termination of the agreement and discontinuation of services by the business associate, or if that is not feasible, by notification of the HHS Secretary. Finally, it is the policy of this organization that organizations that transmit PHI to this Physician Practice or any of its business associates and require access on a routine basis to such PHI, including a Health Information Exchange Organization, a Regional Health Information Organization, or an E-prescribing Gateway, and Personal Health Record vendors, shall be business associates of this Physician Practice.

Training and Awareness

It is the policy of this Physician Practice that all members of our workforce have been trained by the compliance date on the policies and procedures governing protected health information and how this Physician Practice complies with the HIPAA Privacy and Security Rules. It is also the policy of this Physician Practice that new members of our workforce receive training on these matters within a reasonable time (you may elect to enter the exact time frame) after they have joined the workforce. It is the policy of this Physician Practice to provide training should any policy or procedure related to the

HIPAA Privacy and Security Rule materially change. This training will be provided within a reasonable time (you may elect to enter the exact time frame) after the policy or procedure materially changes. Furthermore, it is the policy of this Physician Practice that training will be documented indicating participants, date and subject matter.

Material Change

It is the policy of this Physician Practice that the term "material change" for the purposes of these policies is any change in our HIPAA compliance activities.

Sanctions

It is the policy of this Physician Practice that sanctions will be in effect for any member of the workforce who intentionally or unintentionally violates any of these policies or any procedures related to the fulfillment of these policies. Such sanctions will be recorded in the individual's personnel file.

Retention of Records

It is the policy of this Physician Practice that the HIPAA Privacy and Security Rules' records retention requirement of six years will be strictly adhered to. All records designated by HIPAA in this retention requirement will be maintained in a manner that allows for access within a reasonable period of time. This records retention time requirement may be extended at this organization's discretion to meet with other governmental regulations or those requirements imposed by our professional liability carrier.

Regulatory Currency

It is the policy of this Physician Practice to remain current in our compliance program with HIPAA regulations.

Cooperation with Privacy Oversight Authorities

It is the policy of this Physician Practice that oversight agencies such as the Office for Civil Rights of the Department of Health and Human Services be given full support and cooperation in their efforts to ensure the protection of health information within this organization. It is also the policy of this organization that all personnel must cooperate fully with all privacy and security compliance reviews and investigations.

Investigation and Enforcement

It is the policy of this Physician Practice that in addition to cooperation with Privacy Oversight Authorities, this Physician Practice will follow procedures to ensure that investigations are supported internally and that members of our workforce will not be retaliated against for cooperation with any authority. It is our policy to attempt to resolve all investigations and avoid any penalty phase if at all possible.