ASIAN PACIFIC HEALTH CARE VENTURE, INC.
"working together for community health"

Patient Registration

Date: _____

Patient Last Name	**Patient First Name**	**Patient Middle Name**

Social Security #	**Date of Birth** (mm/dd/yyyy)	**Gender at birth:** □ Male □ Female

Current Gender: □ Male □ Female	**Are you transgender?** □ Yes □ No If Yes, select: □ Trans- Male to Female or □ Trans–Female to Male

Street Address			**Cell Phone**
City	**State**	**Zip**	**Home Phone**

What is your marital status? (check one) □ Divorced □ Married □ Single □ Domestic partner □ Separated □ Widowed	**Day Phone**
Student Status: (check one) □ Full time □ Part- time □ Not a student	**Preferred Phone Number:** □ Home □ Cell □ Day
Patient Email Address:	**Contact Preference:** □ No Preference □ Phone: When is the best time? □ AM □ PM □ Eve □ Anytime □ Email/ Patient Portal □ Mail

Race: Please select all apply from the following race listing:

□ Asian Indian	□ Japanese	□ American Indian/Alaska Native	□ Samoan
□ Bangladeshi	□ Korean	□ Black/African American	□ Other Pacific Islander: _____
□ Cambodian	□ Thai	□ Native Hawaiian	□ White
□ Chinese	□ Vietnamese	□ Guamanian or Chamorro	□ More than one Race
□ Filipino	□ Other Asian:_____		

Preferred language?	**Birthplace:** □ United States □ Other:_____

Year Arrived in US: Please put N/A if you're born in U.S.	**What is your highest Level of education completed?** (Check one) □ Elementary □ Junior High School □ High School □ College □ Graduate Degree or Higher □ N/A	**Citizenship:** □ U.S. □ Permanent Resident □ Tourist □ Other

Do you have a physical or mental disability that has prevented or will prevent you from working for more than a year? □ Yes □ No	**Is it okay to send mail to your address** □ Yes □ No
Emergency Contact Information **Last Name:** **First Name**	**Relationship to patient:** □ Spouse □ Friend □ Parent/Legal Guardian □ Other
Emergency Contact Phone number: □ Home □ Work □ Cell	

Patient's Parent/Guarantor Information (Parent or Legal Guardian for Children Under 18 years)

Parent 1 Information **Last Name:** **First Name:**	**Relationship to patient:** □ Parent □ Foster Parent □ Step parent □ Legal Guardian □Other	
Parent Address **City** **State** **Zip**		**Parent Email address:**
Parent Phone Number	**Parent Date of Birth** (mm/dd/yyyy)	**Parent/Guarantor Gender** □ Male □ Female
If NO second Parent/Guarantor information: Please check the box □ (and skip to Patient Information)		
Parent 2 Information **Last Name:** **First Name:**	**Parent/Relationship to patient:** □ Parent □ Foster Parent □ Step parent □ Legal Guardian □Other	
Parent Address **City** **State** **Zip**		**Parent Email address:**
Parent Phone Number	**Parent Date of Birth** (mm/dd/yyyy)	**Parent Gender** □ Male □ Female

Patient Information

Birth Mother's Full Name (before marriage)
Last (Maiden Name) First Name Middle Name

Are you Homeless? □Yes □ No	**Are you a LAUSD student?** □Yes □ No
Are you or your family members <u>Migratory or Seasonal</u> Agricultural Workers? □Yes □ No	**Are you a veteran of US Armed Forces?** □ Ye s□ No
Do you need an Interpreter? □ Yes □ No	**Ethnicity: Are you Hispanic, Latino/a or Spanish Origin?** □**Yes** □ **No** **If Yes, select:** □ **Mexican, Mexican American, Chicano/a** □ **Puerto Rican** □ **Cuban** □ **Central American** □ **South American** □ **Another Hispanic, Latino/a, or Spanish Origin:** _____
How many people in your family? only include yourself, spouse and minor children under 18 years	**What is your household annual income?** Combined income of the persons listed in your family, if they are working

How did you hear about our clinic? (Please circle all that apply)

APHCV Employee	Brochure/Flyer	Building Signage	Family/Friend/Patient
Health Fair/Festival/Events/Outreach		HMO/Insurance List	Hospital/Doctor/Business/Agency
Internet-Facebook/Instagram		Internet-APHCV Website/Google/Yelp/Etc.	
Newspaper/Magazine/Yellow Pages		School/Outreach	Other: _____

Name of the person who completed the form if it's different from patient: _____

Please turn in the completed forms to Front Office staff.
Thank you.

(SBHC use only)
Parent verification by:
_____
Date: _____

ASIAN PACIFIC HEALTH CARE VENTURE, INC.
"working together for community health"

Combined Consent

Patient Identifying Label

A. CONSENT TO TREATMENT:

I hereby request and consent to diagnostic procedures, tests, and medical treatment, family planning and immunizations as deemed advisable by the professional staff of Asian Pacific Health Care Venture, Inc. (APHCV, Inc.). I am aware that a Physician, a Nurse Practitioner or a Physician Assistant may provide the medical care. Services will be in my best interest, or the best interest of my child or legal charge. I consent to the taking of photographs, videotapes, digital or other images of my medical condition or treatment by clinical staff, and the use of the images for purposes of my diagnosis or treatment or for the clinic's operations including peer review, education and training programs conducted by the clinic. A separate consent is required by me for use of image for non-clinical purposes. I understand that this consent to treatment will be in effect as long as I am seen at any of the Asian Pacific Health Care Venture, Inc. clinic sites. I may cancel this consent in writing. The consent must be cancelled for each clinic that I am seen in.

B. AUTHORIZATION FOR MEDICAL RECORDS RELEASE/REFERRAL AND ASSIGNMENT OF BENEFITS:

I authorize APHCV, Inc. to release medical/social information to persons or agencies directly concerned with and engaged in carrying out a treatment plan for the patient. Also APHCV, Inc. may use and release any part of my medical records necessary to the process of billing third party payers for services rendered on my behalf. I clearly understand that all my information will be kept confidential. I understand that this information will be used to review, investigate, or make payment of a claim, and to review records for quality improvement initiatives, audit compliance, utilization management, and complaint resolution.

I authorize payment directly to Asian Pacific Health Care Venture, Inc. for all medical benefits otherwise payable to me under terms of my insurance. I understand that I am financially responsible for all co-payments, co-insurance, deductibles, and non-covered services. Overpayments on any Asian Pacific Health Care Venture, Inc. account may be applied to my patient balance within the Asian Pacific Health Care Venture, Inc., sites. A photocopy of this authorization shall be considered as effective and as valid as the original.

C. PROTECTED HEALTH INFORMATION DESIGNEE:

I understand that the individuals identified below will be treated by Asian Pacific Health Care Venture, Inc. (APHCV), as individuals involved directly in *my care or my child's care*, and as such APHCV will be allowed to communicate, discuss and release the patient protected health information related to the health care services I or my child receive at APHCV. I understand that the information that can be released are limited to the following: Appointment/Procedure (scheduling, rescheduling, cancelling), Prescription re-fill(s), Laboratory test results, Radiology Examination Results, Referral Inquiries, Billing Inquiries.

Name of Designee: _____ Designee Date of Birth: _____

Designee Phone Number: _____ Relationship to Patient: _____

Name of Designee: _____ Designee Date of Birth: _____

Designee Phone Number: _____ Relationship to Patient: _____

☐ I *decline to provide a protected health information designee contact for myself or my child at this time.*

Patient/Parent/Legal Guardian Signature **(Please circle one)** _____Date: _____

D. ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES:

- I acknowledge that I received the Notice of Privacy Practices from Asian Pacific Health Care Venture, Inc.
- You also have the right to request to be contacted at a different location or by a different method.

APHCV will agree to any reasonable request for alternative methods of contact. If you would like to request an alternative method of contact, please provide the contact information below:

_____

Street Address City State Zip code

Alternative Telephone: _____

Signed: **X**_____ _____

Patient/Parent/Legal Guardian Signature **(Please circle one)** Date

Please print full name and relationship to patient if the patient cannot sign this document.

_____ _____

Full name (Print name of **Parent or Legal Guardian**) Relationship

PLEASE LEAVE THIS PAGE BLANK

ASIAN PACIFIC HEALTH CARE VENTURE, INC.
"working together for community health"

PATIENT PAYMENT RESPONSIBILITY POLICY

1. Payment is expected d in full when services are rendered.

2. Medi-Cal and/or Medicare
If you have Medi-Cal and/or Medicare, please provide us with your current Medi-Cal and/or Medicare Card at each visit. If you have a share of cost, you will be asked to pay that amount at the time of service. **All co-pays, co-insurances, and share of cost are due at time of service**. If your Medi-Cal and/or Medicare claim is denied, you are fully responsible for the cost of the service.

3. Private Insurance
If you have private insurance that we can accept, please provide us with a copy of your insurance card at each visit. **All co-pays, non-cove re d services and deductibles are due at time of service**. If your health insurance claim is denied, you are fully responsible for the cost of the service.

4. Self Pay Patients
Full payment is due at time of service. We accept CASH, CHECKS, CREDIT/DEBIT CARDS. We offer a sliding fee discount and prompt payment incentive if you qualify. Please ask the Front Office staff for additional information.

5. LAUSD students at school-based health centers
Upon the agreement with Los Ange les Unified School District, APHCV shall not charge fees to pre K – 12 students accessing services at school based health centers. APHCV shall charge all other populations as appropriate.

6. Government Funded Programs
We offer several different government funded programs for which you may qualify. If you would like more information, please ask our Front Office staff. Fee for services out of the scope of benefit of government funded program is Patient's responsibility.

7. Sliding Fee Discount Programs
We offer Sliding Fee Discount Program (SFDP) where your fee maybe discounted based on your household income and number of individuals live in the household. You may not eligible or decline to participate at this time, but when you decide to apply or your financial situation changes, you can ask APHCV receptionist staff for the program and provide required documents.

Thank you for choosing us as your health care provider. Please let us know if you have questions or concerns. By signing below you acknowledge and accept our Patient Financial Policy.

X_____ Date _____

Signature of Patient or Responsible Party

X_____ Date _____

Signature of Co-Responsible Party

English: revised 02/07/2020

PLEASE LEAVE THIS PAGE BLANK

ASIAN PACIFIC HEALTH CARE VENTURE, INC.
"working together for community health"

Place Patient label here

PATIENT SAFETY AGREEMENT

At Asian Pacific Health Care Venture, Inc. (APHCV) we do our best to provide a safe place for our patients and visitors to get quality medical care. Therefore, we ask patients and visitors to agree to the following:

1. **RESPECT OTHER CLIENTS AND STAFF:** I promise to respect the privacy and personal safety of all clients and staff of the clinic. I understand that any form of violence or aggressive behavior such as yelling, shouting, hitting, pushing, etc. will not be tolerated. I shall not steal nor vandalize APHCV property (including graffiti).

2. **NO WEAPONS:** I and anyone who comes with me (friends or family) shall not bring weapons of any kind into the clinic area at any time. I understand that if I bring a weapon such as guns, knives, stun guns or any other type of weapon into the clinic I may be asked to leave. I may also be transferred to another facility for my care. If I am legally permitted to carry a weapon (e.g., if you are a peace officer) I shall tell the front desk when I check in.

3. **NO CRIMINAL ACTS:** I shall not do any criminal acts while at APHCV. I understand that APHCV holds right to report any illegal activities to the authorities.

4. **WATCH MY CHILDREN AND BELONGINGS:** I shall supervise and regulate any family members and visitors, in particular children, who may come with me to the clinic. I am also responsible in watching my belongings at all times.

5. **ACCEPTING CONSEQUENCES:** I understand the above responsibilities and will follow them to the best of my ability. I understand that the violation of the above expectations may result in refusal or termination of care at APHCV.

ASIAN PACIFIC HEALTH CARE VENTURE, INC.
"working together for community health"

Place Patient label here

PATIENT RESPONSIBILITIES

Asian Pacific Health Care Venture, Inc. (APHCV) and its staff work with patients in order for them to receive quality and effective medical care, to achieve this goal, we ask all patients to be informed and agree to the following patient responsibilities. **Please place your initials after reading each statement next to the provided space.**

1. **PROVIDE INFORMATION:** I shall provide true and complete information about my past and current illnesses, hospitalizations, medications and other matters relating to my health and answer any questions related to it, to the best of my knowledge. I shall provide up-to-date contact information so that APHCV has a way to contact me when it is necessary. Initial _____

2. **ASK QUESTIONS:** I shall ask questions about my health problems and treatment if they are not clear to me. Initial _____

3. **CALL FOR APPOINTMENT:** If I am feeling bad or have a question about my health care, I will call the clinic. If I feel I need to come into the clinic for medical care, case management, social services, or prescription refills, I will call first. If appointments are not available, I can walk-in to the clinic without an appointment. As a walk-in, I understand I may have to wait for an appointment and a same day appointment is not guaranteed. Initial _____

4. **KEEP MY APPOINTMENT:** I shall keep all my scheduled appointments and arrive on time. If I cannot keep my appointment, I will call the clinic and cancel my appointment at least 24 hours before my appointment time. I shall arrive about 20 or 40 minutes prior to my scheduled appointment, depending on my appointment and/or insurance program renewal if needed, to allow enough time to complete my check-in process. *I understand my appointment will be cancelled, re-scheduled or moved to another time if I arrive after my given scheduled check-in time*. Initial _____

5. **RESPONSIBLE FOR MY CARE:** I understand that I am ultimately responsible for my own health care and for that of my family. It is my responsibility to make and keep appointments for treatment of diseases or conditions and preventative care such as health check-ups, immunizations, pap smears, mammograms, or HIV tests. I understand that I am responsible for the outcomes if I do not follow the instructions of health care providers. Initial _____

6. **INDIVIDUALS WITH DISABILITIES USING SERVICE ANIMALS**: I understand that I am responsible for the care and supervision of my service animal at all times, which includes leashing, toileting, cleaning up and disposal of animal waste, feeding. I understand that APHCV may require a service animal to be removed from the clinic immediately if APHCV finds any of the following; (a) the service animal is disruptive, out of control; or (b) the service animal causes any harm to patients/staff. Initial _____

I have read, understood, and agreed to adhere to both the Patient Safety Agreement and the Patient Responsibilities.

_____ _____

Patient/Parent/Legal Guardian Signature **(Please circle one)** Date

_____

Print Name

APHCV Administrative Office | 4216 Fountain Avenue | Los Angeles, California 90029 | 323.644.3880 | www.aphcv.org

Belmont Health Center
180 Union Place
Los Angeles, California 90026
323.644.3885

El Monte/Rosemead Health Center
9960 Baldwin Place
El Monte, California 91731
626.774.2988

John Marshall High School Health Center
3939 Tracy Street
Los Angeles, California 90027
323.665.1129

Los Feliz Health Center
1530 Hillhurst Avenue
Los Angeles, California 90027
323.644.3888

(SBHC use only)

Parent verification by:

_____

Date: _____

ASIAN PACIFIC HEALTH CARE VENTURE, INC.

"working together for community health"

Patient Identifying Label

Telehealth/Telephone Informed Consent

1. I agree to receive health care services via Telehealth/Telephone. I understand that:
    a. I have the right to access covered services through an in-person, face- to-face visit or through Telehealth/Telephone.
    b. The use of Telehealth/Telephone is voluntary, and I may withdraw my consent to, or stop receiving services through Telehealth/Telephone at any time without affecting my ability to access covered services in the future.
    c. My insurance provides coverage for transportation services to in-person services when other resources have been reasonably exhausted.
    d. There may be limitations or risks related to receiving services through Telehealth/Telephone as compared to an in-person visit. For example:
        - Telehealth/Telephone involves alternative forms of communication that may reduce video and/or audio quality comparing to in person face-to-face visit.
        - Telehealth/Telephone sessions could be disrupted, and medical evaluation or treatment could be delayed due to deficiencies or technical failures.
        - Information transmitted may not be sufficient (e.g., poor resolution of video, poor audio) to allow for appropriate medical decision making by the provider. Your provider may determine that telehealth and/or telephone service are not appropriate for certain evaluation/treatment.
        - Public devices and/or network that may be accessed by someone else other than yourself are not secure and should be avoided. It is strongly recommended to use a secure and/or private device and internet network.
        - A timely response to emergencies during Telehealth/Telephone session may be limited. If there is an emergency during a Telehealth/Telephone session, APHCV will contact emergency services and patient's emergency contacts if needed clinically necessary.
2. I have read this document carefully, understand the potential limitations and risks of receiving services via Telehealth/Telephone, and have had my questions answered to my satisfaction.

Signed: **X**_____ _____

Patient/Parent/Legal Guardian Signature **(Please circle one)** **Date**

Please print full name and relationship to patient if the patient cannot sign this document.

_____

Full name (Print name of **Parent or Legal Guardian**) Relationship

ASIAN PACIFIC HEALTH CARE VENTURE, INC.
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Consent for Release/Exchange of Information to/with LAUSD form

We, Asian Pacific Health Care Venture (APHCV) - John Marshall High School Health Center (APHCV Clinic), are requesting your written consent for the release/exchange of information with Los Angeles Unified School District (LAUSD). The information will be used to coordinate the appropriate services to you/your child. In addition, LAUSD may request you/your child's information from APHCV for attendance verification, liability, or for the safety and management of school grounds.

****

I hereby authorize APHCV-John Marshall High School Health Center to disclose the following information regarding _____ (my name/name of my child), D.O.B._____:

- Appointment information (date and time)
- When I am/my child is referred off campus for emergent/urgent care

I understand that the APHCV Clinic is neither a part of the regular nor the ongoing program of the school or LAUSD. The APHCV Clinic services are made available at the school site for my convenience and to obtain health care services for my child/self. If I do not sign this authorization, I understand that my child or I am still eligible for care and it will not affect the quality of care my child or I receive. Once the APHCV Clinic discloses such information to LAUSD, the use of such information is governed by LAUSD rules and regulations and APHCV no longer has authority over the released information. This consent will not override Authorization to Use or Disclosure of Protected Health Information (PHI).

This consent is effective until I am/my child is no longer enrolled with LAUSD schools _____ (expected graduation date) or I revoke the consent in writing.

I request a copy of this authorization: Yes ☐ No ☐

_____ _____

Name of Student Date

_____ _____

Parent/Guardian Signature Date

_____ _____

Witness Signature/Print Name Date

PLEASE LEAVE THIS PAGE BLANK

Patient Label

Open Payments Database Notice

English: Open Payments Database Notice

The Open Payment 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 **openpaymentsdata.cms.gov.**

Spanish: Aviso de la base de datos de Revelación de Pagos

La base de datos de Revelación de Pagos es una herramienta federal que se utiliza para rastrear los pagos realizados por compañías de medicamentos y dispositivos a médicos y hospitales docentes. Se puede encontrar en openpaymentsdata.cms.gov.

Thai: ขอแจ้งให้ทราบเรื่อง ฐานข้อมูลสาธารณะ เกี่ยวกับการชำระเงินให้ทางการแพทย์

ฐานข้อมูลสาธารณะ เกี่ยวกับการชำระเงินให้ทางการแพทย์ คือบริการของรัฐบาลกลาง เพื่อให้บุคคลทั่วไปสามารถค้นหาการชำระเงินที่ทำโดยบริษัทยาและอุปกรณ์ทางการแพทย์ ที่สั่งจ่ายให้แก่แพทย์วิชาชีพ และโรงพยาบาลที่สอนต่างๆ ซึ่งท่านสามารถเข้าไปค้นหาข้อมูลได้ที่หน้าเวบไซต์ openpaymentsdata.cms.gov.

Khmer: ប្រកាសបើកចំហរពត៌មានដែលតំកល់ទុក អំពីការទូទាត់ប្រាក់

ការបើកចំហរពត៌មានដែលតំកល់ទុក អំពីការទូទាត់ប្រាក់ គឺជាឧបករណ៍នៃសហព័ន្ធមួយដែលប្រើដើម្បីស្វែងរកការទូទាត់ប្រាក់ ដែលបានធ្វើឡើងដោយក្រុមហ៊ុនថ្នាំពេទ្យ និងក្រុមហ៊ុនឧបករណ៍ពេទ្យ ឱ្យដល់គ្រូពេទ្យ និងមន្ទីពេទ្យដែលបង្រៀន។ អាចរកឃើញនៅក្នុងវិបសាយ openpaymentsdata.cms.gov.

Bengali: পেমেন্ট ডাটাবেসের নোটিশ খুলুন

ওপেন পেমেন্ট ডেটাবেস হল একটি ফেডারেল টুল যা ঔষুধ এবং ডিভাইস কোম্পানির দ্বারা চিকিৎসক এবং শিক্ষাদানকারী হাসপাতালগুলিতে করা অর্থপ্রদান অনুসন্ধান করতে ব্যবহৃত হয়। এটি openpaymentsdata.cms.gov এ পাওয়া যাবে।

Japanese: オープンペイメントデーターベースのお知らせ

オープンペイメントデーターベースは製薬会社や機器会社が医師や教育病院におこなった支払いを検索するために使用される連邦政府のツールです。**openpaymentsdata.cms.gov.**でご確認いただけます。

Chinese: 打開支付數據庫通知

Open Payment Database 是一種聯邦工具，用於搜索藥品和設備公司向醫生和教學醫院支付的款項。它可以在 openpaymentsdata.cms.gov. 找到

Vietnamese: Mở thông báo cơ sở dữ liệu thanh toán

Cơ sở dữ liệu thanh toán mở là một công cụ liên bang được sử dụng để tìm kiếm các khoản thanh toán do các công ty dược phẩm và thiết bị thực hiện cho các bác sĩ và bệnh viện giảng dạy. Nó có thể được tìm thấy tại openpaymentsdata.cms.gov.

Signed: _____ Date: _____

Patient or Patient Representative

All sites: Effective 01/01/2023

PLEASE LEAVE THIS PAGE BLANK

Asian Pacific Health Care Venture, Inc.

Notice of Privacy Practices

Your Information. Your Rights. Our Responsibilities.

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.**

Your Rights

When it comes to your health information, you have certain rights.
This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.

Ask us to limit what we use or share	• You can ask us **not** to use or share certain health information for treatment, payment, or our operations.
	  • We are not required to agree to your request, and we may say "no" if it would affect your care.
	• If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.
	  • We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on the back page. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** • We will not retaliate against you for filing a complaint.

Your Choices

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

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

continued on next page

Our Uses and Disclosures

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as:
	  • Preventing disease
	  • Helping with product recalls
	  • Reporting adverse reactions to medications
	  • Reporting suspected abuse, neglect, or domestic violence
	  • Preventing or reducing a serious threat to anyone's health or safety

Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you:
	  • For workers' compensation claims
	  • For law enforcement purposes or with a law enforcement official
	  • With health oversight agencies for activities authorized by law
	  • For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Asian Pacific Health Care Venture, Inc. (APHCV) does not create or maintain psychotherapy notes as defined by HIPAA.

In addition to HIPAA, APHCV patient's privacy is protected under The Confidentiality of Medical Information Act (CMIA). The CMIA is a state law that protects the confidentiality of individually identifiable medical information obtained by a health care provider.

APHCV will ask for your written authorization each time to disclose HIV test results unless disclosure is permitted by law.

APHCV provides you an electronic access to your medical record and other health information we have about you. Please ask APHCV Front Office staff how to enroll to APHCV Patient Portal "My APHCV" or contact the Privacy Officer at (323) 644-3880 or HIPAA@aphcv.org.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

This Notice of Privacy Practices applies to the following organizations.

APHCV-Belmont Health Center: 180 Union Place, Los Angeles, CA 90026
APHCV-El Monte/Rosemead Health Center: 9960 Baldwin Place, El Monte, CA 91731
APHCV-John Marshall High School Health Center: 3939 Tracy Street, Los Angeles, CA 90027
APHCV-Los Feliz Health Center: 1530 Hillhurst Ave., Los Angeles, CA 90027

Asian Pacific Health Care Venture, Inc.
Administrative Office
4216 Fountain Avenue
Los Angeles, CA 90029
www.aphcv.org

For questions or more information about this document, please contact:
Privacy Officer: (323) 644-3880 or HIPAA@aphcv.org

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