New Patient Confidential Intake Form

Patient Information:

Patient name		Sex M F	Date of birth	Cell phone ☐ **I would like to receive text message appt reminders**
Address				Home phone
Email address			Social security number	Fax number
Emergency contact name			Relationship	Emergency contact phone number
Employer name and address				Employer phone number

Referral Information:

Referring doctor name	Referring doctor address or city	Referring doctor phone number
Primary care physician name ☐ I do not have a primary care physician	Primary care physician address or city	Primary care physician phone number

Insurance Information:

Primary insurance	Member ID	Group ID	Effective date
Secondary Insurance	Member ID	Group ID	Effective date

Primary pharmacy	Primary pharmacy address	Primary pharmacy phone number

I certify that I have answered these questions completely, honestly and to the best of my knowledge.

______________________________ ______________________________ __________________

Patient printed name Patient signature Date

If you are having neck and/or arm pain, please fill out section A. If you are having back and/or leg pain, please fill out section B. All patients must fill out sections C-J and sign on page 5. A copy of this assignment shall be as valid as the original.

Youjeong Kim, M.D.
Golden Gate Spine
Spine Surgeon

1236 Sutter Street
San Francisco, CA 94109
Tel: (415) 775-1095

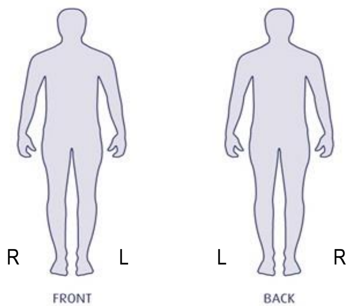
Reason For Visit:

Chief complaint (check all that apply)					Height
❍ Neck pain	❍ Arm pain	❍ Arm numbness	❍ Arm weakness	❍ Other	
❍ Back pain	❍ Leg pain	❍ Leg numbness	❍ Leg weakness	______________________________	Weight

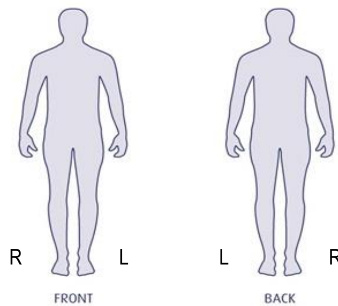
What started the pain/problem?	
How long has the pain/problem been present?	Has the problem worsened lately? If so, how recently? ❍ Yes ❍ No
Please indicate which is the dominate hand you write with?	❍ Right ❍ Left

Type of pain: (please shade where pain is located)

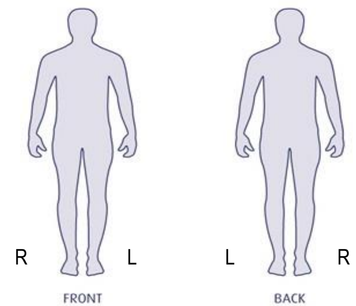
Burning sensation



Stabbing/sharp



Ache



A. For patients with NECK and/or ARM pain:

1. What percentage (%) of your pain is neck pain and what % is arm pain? ________ neck pain ________ arm pain (total must equal 100%)
   i. If there is arm pain, what % is in the right arm and what % is in the left arm? ________ right arm ________ left arm
2. There is (check all that apply):

	RIGHT			LEFT		
	PAIN	NUMBNESS	WEAKNESS	PAIN	NUMBNESS	WEAKNESS
Back of the head (C2, C3)	❍	❍	❍	❍	❍	❍
Side of the neck (C3, C4)	❍	❍	❍	❍	❍	❍
Neck (C4)	❍	❍	❍	❍	❍	❍
Upper chest/clavicle (C4, C5)	❍	❍	❍	❍	❍	❍
Shoulder (C5, C6)	❍	❍	❍	❍	❍	❍
Upper back (C6, C7, C8)	❍	❍	❍	❍	❍	❍
Back of the arm (C7, C8)	❍	❍	❍	❍	❍	❍
Front of the arm (C5, T1)	❍	❍	❍	❍	❍	❍
Thumb (C6)	❍	❍	❍	❍	❍	❍
Pointer or middle finger (C7)	❍	❍	❍	❍	❍	❍
Ring finger or pinky (C8)	❍	❍	❍	❍	❍	❍

3. Raising the arm: ❍ improves the pain ❍ worsens the pain ❍ does not affect the pain
4. Moving the neck: ❍ improves the pain ❍ worsens the pain ❍ does not affect the pain
5. Do you have difficulties picking up small objects like coins or buttons? ❍ yes ❍ no
6. Do you have balance problems or trip frequently? ❍ yes ❍ no
7. Do you have headaches in the back of the head? ❍ yes ❍ no

B. For patients with BACK and/or LEG pain:

1. What percentage (%) of your pain is back pain and what % is leg pain? ________ back pain ________ leg pain (total must equal 100%)
   i. If there is leg pain, what % is in the right leg and what % is in the left leg? ________ right leg ________ left leg
2. There is (check all that apply):

	RIGHT			LEFT		
	PAIN	NUMBNESS	WEAKNESS	PAIN	NUMBNESS	WEAKNESS
Lower back (L1-L5)	❍	❍	❍	❍	❍	❍
Groin (L1, L2)	❍	❍	❍	❍	❍	❍
Hip (L1, L2, L3)	❍	❍	❍	❍	❍	❍
Front of thigh (L3, L4)	❍	❍	❍	❍	❍	❍
Outer side of thigh (C4, C5)	❍	❍	❍	❍	❍	❍
Knee (L4)	❍	❍	❍	❍	❍	❍
Shin (L4, L5)	❍	❍	❍	❍	❍	❍
Buttocks (S1-S5)	❍	❍	❍	❍	❍	❍
Back of the leg (S1, S2)	❍	❍	❍	❍	❍	❍
Top of the foot (L4, L5)	❍	❍	❍	❍	❍	❍
Little toe (S1)	❍	❍	❍	❍	❍	❍
Ankle (L5)	❍	❍	❍	❍	❍	❍

3. The worst position for the pain is: ❍ sitting ❍ standing ❍ walking
4. How many minutes can you stand in one place without pain? ❍ 0-10 ❍ 10-20 ❍ 20-30 ❍ 30-45 ❍ 45-60 ❍ 60+
5. How many minutes can you walk without pain? ❍ 0-10 ❍ 10-20 ❍ 20-30 ❍ 30-45 ❍ 45-60 ❍ 60+
6. Lying down: ❍ improves the pain ❍ worsens the pain ❍ does not affect the pain
7. Leaning forward: ❍ improves the pain ❍ worsens the pain ❍ does not affect the pain

C. All patients must answer the following:

1. Coughing or sneezing: ❍ improves the pain ❍ worsens the pain ❍ does not affect the pain
2. Have you lost bladder control? ❍ yes ❍ no if yes, for how long? ________________________
3. Have you missed work due do this problem? ❍ yes ❍ no if yes, for how long? ________________________
4. Have you had other treatments for this problem? ❍ yes ❍ no

	NECK	BACK
Physical therapy / Exercise	❍	❍
# of sessions within last 6 months?		
Massage	❍	❍
Ultrasound	❍	❍
Traction	❍	❍
Chiropractor/Manipulation	❍	❍
# of sessions within last 6 months?		
TENS unit	❍	❍
Braces	❍	❍
Anti-inflammatory medications	❍	❍
Narcotic medications	❍	❍

	NECK	BACK
Spine/Epidural Steroid Injections	❍	❍
How many injections?		
Length of time of relief?		
Trigger point injections	❍	❍
How many injections?		
Length of time of relief?		
Other (please list below)		
Shoulder injections	❍	❍

5. Have you taken any medications for this problem? ❍ yes ❍ no if yes, please list below:

MEDICATION	DOSAGE	FREQUENCY

6. Have you seen other doctors about this problem? ❍ yes ❍ no if yes, please list below:

DOCTOR'S NAME	SPECIALTY	CITY	TREATMENTS

7. Have you had any tests done to evaluate the problem? ❍ yes ❍ no if yes, please list below:

	NECK	BACK	DATE	LOCATION	DATE	LOCATION
X-RAYS	❍	❍				
MYELOGRAM	❍	❍				
CT SCAN	❍	❍				
MRI	❍	❍				
EMG	❍	❍				
BONE SCAN	❍	❍				

D. Review of systems: Check all that apply

❍ **None apply**	❍ Heart or chest pain	❍ Frequent diarrhea	❍ Recent weight change
❍ Fever or chills	❍ Bone/joint pain	❍ Frequent constipation	❍ Skin rash or burning
❍ Frequent headaches	❍ Swollen ankles	❍ Hemorrhoids	❍ Open sores
❍ Change of vision	❍ Calf cramps when walking	❍ Frequent urination	❍ Thyroid problems
❍ Loss of hearing	❍ Poor appetite	❍ Burning on urination	❍ Night sweats
❍ Nosebleeds	❍ Toothache	❍ Difficulty urinating	❍ Tremors
❍ Difficulty swallowing	❍ Gum trouble	❍ Depression	❍ Fibromyalgia
❍ Hoarseness	❍ Nausea or vomiting	❍ Blackouts	❍ Multiple sclerosis
❍ Morning cough	❍ Stomach pain	❍ Seizures	❍ Other (please list below)
❍ Shortness of breath	❍ Ulcers	❍ Sleep disturbance	
❍ Abnormal heartbeat	❍ Frequent belching	❍ Hot or cold spells	

E. Medical history: Check all that apply

❍ **None apply**	❍ Diabetes	❍ HIV	❍ Thyroid trouble
❍ Heart attack	❍ Stroke	❍ AIDS	❍ Bleeding disorders
❍ Heart failure	❍ Seizures	❍ Tuberculosis	❍ Anemia
❍ High blood pressure	❍ Mental illness	❍ Asthma	❍ Serious injuries (explain)
❍ Osteoarthritis	❍ Kidney stones	❍ Blood clot in leg	
❍ Rheumatoid arthritis	❍ Kidney failure	❍ Blood clot in arm	
❍ Ankylosing spondylitis	❍ Cancer	❍ Stomach ulcers	❍ Other (please list below)
❍ Gout	❍ Alcoholism	❍ Liver trouble	
❍ Osteoporosis	❍ Lung disease	❍ Hepatitis	

F. Surgical history: ❍ Not applicable

DATE	OPERATION	SURGEON

G. Family history: Check all that apply

❍ **None apply**	❍ Arthritis	❍ Kidney trouble	❍ Other (please list below)
❍ Stroke	❍ Gout	❍ Kidney stones	
❍ Heart trouble	❍ Seizures	❍ Cancer	
❍ High blood pressure	❍ Spine problems	❍ Bleeding disorders	
❍ Diabetes	❍ Mental illness	❍ Alcoholism	

H. Current medications:

Are you currently taking any medications? ❍ yes ❍ no if yes, please list below:

MEDICATION	DOSAGE	FREQUENCY

I. Allergies:

Are you allergic to any medications/foods? ❍ yes ❍ no known drug allergies if yes, please list below:

MEDICATION/FOOD	REACTION	SEVERITY

J. Social history:

1. Work status: ❍ full time ❍ part time ❍ homemaker ❍ unemployed ❍ retired ❍ disabled ❍ on leave
   i. Occupation: ____
2. Marital status: ❍ married ❍ single ❍ divorced ❍ widowed
   i. Number of living children: __________
   ii. Number of people in household (including yourself): __________
3. Tobacco use: ❍ never ❍ previous ❍ current
   i. Type of tobacco: ❍ cigar ❍ cigarettes ❍ chew ❍ pipe ❍ e-cigarette/vaping
   ii. Frequency: __________ packs a day for __________ years
   iii. When did you quit: _________________ after smoking for __________ years (total)
4. Current Marijuana Use: ❍ CBD ❍ THC ❍ not applicable
5. Alcohol consumption: ❍ never ❍ social ❍ more than 2x week ❍ alcoholic ❍ recovering alcoholic
6. Drug overuse/abuse: ❍ never ❍ currently ❍ in the past
7. Because of this spine problem, I plan to file: ❍ a lawsuit ❍ a worker's compensation claim ❍ neither
8. My pain or discomfort level is:

	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
In the morning	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍
At night	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍
At rest	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍
After activity	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍

NOTICE OF OFFICE POLICIES

YOUJEONG KIM, M.D.

ACKNOWLEDGMENT

I acknowledge that I have reviewed the attached Notice of Office Policies regarding:

- Assignment of benefits
- Financial responsibility, insurance coverage and verification
- Authorization to release medical information for billing purposes
- No-show policy: Failure to show for two visits will result in discharge from our practice
- Surgery cancellation policy: $250 after a surgery date is confirmed
- Forms: $15/page (i.e. work-related forms, letters, etc.); EDD forms $30 flat fee/request
- No refunds are issued for services provided
- Pain medication management
- HIPAA notice and acknowledgement

____
Signature of Patient or Personal Representative

____
(print name)

If you are signing as the personal representative of the patient, please describe your relationship with the patient:

____

(Notice of Office Policies and Privacy Policies to be attached)

NOTICE OF OFFICE POLICIES

YOUJEONG KIM, M.D.

THIS NOTICE DESCRIBES OFFICE POLICIES AND INFORMATION.

I. Assignment of benefits

I hereby assign to Youjeong Kim, M.D., Inc., 1236 Sutter Street, San Francisco, CA, 94109, all of my right, title, and interest in and to any and all health care and/or surgical benefits otherwise payable to me for medical treatment.

II. Financial responsibility

I acknowledge that I am still responsible for paying Youjeong Kim, M.D. to the extent that the relevant insurer, plan or payor does not pay Youjeong Kim, M.D. I agree that I am responsible for paying Youjeong Kim, M.D. for the full amount of the charges for medical treatment provided by Youjeong Kim, M.D.

I acknowledge that it is my responsibility to confirm the status and extent of my health insurance coverage.

I agree to satisfy payment at the time of service, including any payments toward my deductible. Furthermore, I understand that any outstanding balance must be satisfied prior to the next appointment.

I agree to immediately remit to Youjeong Kim, M.D. any and all payments subject to this assignment that I nonetheless receive directly from the relevant insurer, plan, or payor.

I understand that my failure to make payments to Youjeong Kim, M.D. may cause Youjeong Kim, M.D. to incur collection costs and attorney's fees to collect such payments from me, and I agree that I shall be liable for Youjeong Kim, M.D.'s collections costs and attorney's fees (plus interest on my outstanding balance at the rate of 10% per annum or the maximum amount allowed by law).

I understand that refunds are not issued for services provided.

III. Authorization to release medical information for billing purposes

I hereby authorize the release of medical information necessary to file a claim with my insurance carrier or other third party payer I agree to the assignment of benefits otherwise payable to me, Golden Gate Spine and Youjeong Kim, M.D.

IV. No show and cancellation policy

I acknowledge that cancellations must be made at least 2 business days in advance. Any appointments on Monday must be cancelled by close of business on Thursday afternoon, and any appointments on Wednesday must be cancelled by close of business on Monday afternoon. We do not charge a cancellation fee. If you must late cancel, please call or email our office ahead of time. We have a strict two strike no-show fee; if you no-show more than 2 visits, we reserve the right to discharge you from our practice.

I acknowledge that cancellations, regarding scheduling surgery, must be made prior to confirmation of a surgery date. In the event that my primary care physician does not clear me for surgery, I will be relieved of any cancellation charge. If I am uncertain whether surgery is the right option for me, I will consider so before committing to a surgery date. If I do commit to a surgery date and decide to cancel during the scheduling process, I will be charged $200 which is not covered by my medical insurance.

V. Forms

I acknowledge I will be charged $15.00 per page for any forms, such as disability forms, work-related forms, letters,

etc. Due to the complexity and volume of this paperwork received in the office, I will allow 5-10 business days for the completion of these forms and payment is due before any forms are released.

VI. Pain management and medications

I acknowledge that Dr. Kim can manage acute pain, including post-surgery pain management for up to 6 weeks. For management of pain medications of periods greater than 6 weeks, I will seek or be referred to a pain management specialist. I also acknowledge that in accordance to California law, all narcotic medications must be written on a physical prescription and picked up from the clinic/office at the time of an appointment with Dr. Kim.

NOTICE OF PRIVACY PRACTICES

YOUJEONG KIM, M.D.

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

PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices is being provided to you as a requirement of the Health Insurance Portability and Accountability Act (HIPAA). This Notice describes how we may use and disclose your protected health information to carry out treatment, payment, or healthcare operations, and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information in some cases. Your "protected health information" means any of your written and oral health information, including demographic data, that can be used to identify you. This is health information that is created or received by your healthcare provider (Youjeong Kim, M.D.) and that relates to your past, present, or future physical or mental health or condition.

VII. Uses and Disclosures of Protected Health Information

The provider may use your protected health information for purposes of providing treatment, obtaining payment for treatment, and conducting healthcare operations. Your protected health information may be used or disclosed only for these purposes unless the provider has obtained your authorization or the use or disclosure is otherwise permitted by the HIPAA privacy regulations or state law. Disclosures of your protected health information for the purposes described in this Notice may be made in writing, orally, or by facsimile.

A. Treatment. We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party for treatment purposes. For example, we may disclose your protected health information to a pharmacy to fulfill a prescription, to a laboratory to order a blood test, or to a home health agency that is providing care in your home. We may also disclose protected health information to other physicians who may be treating you or consulting with your physician with respect to your care. In some cases, we may also disclose your protected health information to an outside treatment provider for purposes of the treatment activities of the other provider.

B. Payment. Your protected health information will be used, as needed, to obtain payment for the services that we provide. This may include certain communications to your health insurer to get approval for the treatment that we recommend. For example, if a hospital admission is recommended, we may need to disclose information to your health insurer to get prior approval for the hospitalization. We may also disclose protected health information to your insurance company to determine whether you are eligible for benefits or whether a particular service is covered under your health plan. In order to get payment for your services, we may also need to disclose your protected health information to your insurance company to demonstrate the medical necessity of the services or, as required by your insurance company, for utilization review. We may also disclose patient information to another provider involved in your care for the other provider's payment activities.

C. Operations. We may use or disclose your protected health information, as necessary, for our own healthcare operations in order to facilitate the function of the provider and to provide quality care to all patients. Healthcare operations include such activities as:

- Quality-assessment and -improvement activities
- Employee-review activities
- Training programs, including those in which students, trainees, or practitioners in health care learn under supervision
- Accreditation, certification, licensing, or credentialing activities

- Review and auditing, including compliance reviews, medical reviews, legal services, and the maintaining of compliance programs
- Business management and general administrative activities

In certain situations, we may also disclose patient information to another provider or health plan for its healthcare operations.

D. Other uses and Disclosures. As part of treatment, payment, and healthcare operations, we may also use or disclose your protected health information for the following purposes:

- To remind you of an appointment
- To inform you of potential treatment alternatives or options
- To inform you of health-related benefits or services that may be of interest to you
- To contact you to raise funds for the provider or an institutional foundation related to the provider (if you do not wish to be contacted regarding fundraising, please contact our Privacy Officer)

VIII. Uses and Disclosures beyond Treatment, Payment, and Healthcare Operations Permitted without Authorization or Opportunity to Object

Federal privacy rules allow us to use or disclose your protected health information without your permission or authorization for a number of reasons, including the following:

A. When Legally Required. We will disclose your protected health information when we are required to do so by any federal, state, or local law.

B. When There Are Risks to Public Health. We may disclose your protected health information for the following public activities and purposes:

- To prevent, control, or report disease, injury, or disability, as permitted by law
- To report vital events such as a birth or death, as permitted or required by law
- To conduct public health surveillance, investigations, and interventions, as permitted or required by law
- To collect or report adverse events and product defects to the FDA; track FDA-regulated products; enable product recalls, repairs, or replacements; and conduct postmarketing surveillance
- To notify a person who has been exposed to a communicable disease or who may be at risk of contracting or spreading a disease, as authorized by law.
- To report to an employer information about an individual who is a member of the workforce, as legally permitted or required

C. To Report Abuse, Neglect, or Domestic Violence. We may notify government authorities if we believe that a patient is the victim of abuse, neglect, or domestic violence. We will make this disclosure only when specifically required or authorized by law to do so or when the patient agrees to the disclosure.

D. To Conduct Health-Oversight Activities. We may disclose your protected health information to a health-oversight agency for activities including audits; civil, administrative, or criminal investigations, proceedings, or actions; inspections; licensure or disciplinary actions; or other activities necessary for appropriate oversight as authorized by law. We will not disclose your health information if you are the subject of an investigation and your health information is not directly related to your receipt of health care or public benefits.

E. In Connection with Judicial and Administrative Proceedings. We may disclose your protected health information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal, as expressly authorized by such order or in response to a subpoena in some circumstances.

F. For Law-Enforcement Purposes. We may disclose your protected health information to a law-enforcement official for law-enforcement purposes as follows:

- As required by law for the reporting of certain types of wounds or other physical injuries
- Pursuant to court order, court-ordered warrant, subpoena, summons, or similar process
- For the purpose of identifying or locating a suspect, fugitive, material witness, or missing person
- Under certain limited circumstances, when you are the victim of a crime
- To a law-enforcement official if the provider has a suspicion that your death was the result of criminal conduct
- In an emergency in order to report a crime

G. To Coroners and Funeral Directors and for Organ Donation. We may disclose protected health information to a coroner or medical examiner for identification purposes, to determine cause of death, or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out his or her duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ-, eye-, or tissue-donation purposes.

H. For Research Purposes. We may use or disclose your protected health information for research when the use or disclosure for research has been approved by an institutional review board or privacy board that has reviewed the research proposal and research protocols to address the privacy of your protected health information.

I. In the Event of a Serious Threat to Health or Safety. We may, consistent with applicable law and ethical standards of conduct, use or disclose your protected health information if we believe, in good faith, that such use or disclosure is necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health and safety of the public.

J. For Specified Government Functions. In certain circumstances, the federal regulations authorize the provider to use or disclose your protected health information to facilitate specified government functions relating to military and veterans' activities, national-security and intelligence activities, protective services for the U.S. President and others, medical-suitability determinations, correctional institutions, and law-enforcement custodial situations.

K. For Worker's Compensation. The provider may release your health information to comply with Workers' Compensation laws or similar programs.

IX. Uses and Disclosures Permitted without Authorization, but with Opportunity to Object

We may disclose your protected health information to your family member or a close personal friend if it is directly relevant to the person's involvement in your care or to the payment related to your care. We can also disclose your information in connection with trying to locate or notify family members, or others involved in your care, concerning your location, condition, or death.

You may object to these disclosures. If you do not object to these disclosures or we can infer from the circumstances that you do not object, or if we determine, in the exercise of our professional judgment, that it is in your best interests for us to make disclosure of information that is directly relevant to the person's involvement with your care, we may disclose your protected health information as described.

X. Uses and Disclosures That You Authorize

Other than as stated above, we will not disclose your health information other than with your written authorization. You may revoke your authorization in writing at any time, except to the extent that we have taken action in reliance upon the authorization.

XI. Your Rights

You have the following rights regarding your health information:

A. The Right to Inspect and Copy Your Protected Health Information. You may inspect and obtain a copy of your protected health information that is contained in a designated record set for as long as we maintain the protected health information. A "designated record set" contains medical and billing records and any other records that your physician and the provider use for making decisions about you.

Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding; and protected health information that is subject to a law that prohibits access to protected health information. Depending on the circumstances, you may have the right to have a decision to deny access reviewed.

We may deny your request to inspect or copy your protected health information if, in our professional judgment, we determine that the access requested is likely to endanger your life or safety or that of another person, or that it is likely to cause substantial harm to another person referenced within the information. You have the right to request a review of this decision.

To inspect and copy your medical information, you must submit a written request to the Privacy Officer whose contact information is listed toward the end of this Notice. If you request a copy of your information, we may charge you a fee for the costs of copying and mailing or for other costs incurred by us in complying with your request.

Please contact our Privacy Officer if you have questions about access to your medical record.

B. The Right to Request a Restriction on Uses and Disclosures of Your Protected Health Information. You may ask us not to use or disclose certain parts of your protected health information for the purposes of treatment, payment, or healthcare operations. You may also request that we not disclose your health information to family members or friends who may be involved in your care or for notification purposes as described in this Notice. Your request must state the specific restriction requested and to whom you want the restriction to apply.

The provider is not required to agree to a restriction that you may request. We will notify you if we deny your request to a restriction. If the provider agrees to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. Under certain circumstances, we may terminate our agreement to a restriction. You may request a restriction by contacting the Privacy Officer.

C. The Right to Request to Receive Confidential Communications from Us by Alternative Means or at an Alternative Location. You have the right to request that we communicate with you in certain ways. We will accommodate reasonable requests. We may condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not require you to provide an explanation for your request. Requests must be made in writing to our Privacy Officer.

D. The Right to Have Your Physician Amend Your Protected Health Information. You may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us, and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Requests for amendment must be in writing and must be directed to our Privacy Officer. In this written request, you must also provide a reason to support the requested amendments.

E. The Right to Receive an Accounting. You have the right to request an accounting of certain disclosures of your protected health information made by the provider. This right applies to disclosures for purposes other than treatment, payment, or healthcare operations as described in this Notice. We are also not required to account for

disclosures that you requested, disclosures that you agreed to by signing an authorization form, disclosures for a facility directory, to friends or family members involved in your care, or certain other disclosures we are permitted to make without your authorization. The request for an accounting must be made in writing to our Privacy Officer. The request should specify the time period sought for the accounting. We are not required to provide an accounting for disclosures that have taken place prior to April 14, 2003. Accounting requests may not be made for periods of time in excess of six (6) years. We will provide the first accounting you request during any 12-month period without charge. Subsequent accounting requests may be subject to a reasonable cost-based fee.

F. The Right to Obtain a Paper Copy of This Notice. Upon request, we will provide a separate paper copy of this Notice even if you have already received a copy of the Notice or have agreed to accept this Notice electronically.

XII. Our Duties

The provider (Youjeong Kim, M.D.) is required by law to maintain the privacy of your health information and to provide you with this Notice detailing our duties and privacy practices. We are required to abide by terms of this Notice as they may be amended from time to time. We reserve the right to change the terms of this Notice and to make the new Notice provisions effective for all protected health information that we maintain. If the provider changes its Notice, we will provide a copy of the revised Notice by sending a copy of the revised Notice via regular mail or through in-person contact.

XIII. Complaints

You have the right to express complaints to the provider and to the Secretary of Health and Human Services if you believe that your privacy rights have been violated. You may complain to the provider by contacting the Youjeong Kim, M.D., Privacy Officer orally or in writing, using the contact information below. We encourage you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

XIV. Contact Person

The provider's contact person for all issues regarding patient privacy and your rights under the federal privacy standards is the Privacy Officer. Information regarding matters covered by this Notice can be requested by contacting the Privacy Officer. Complaints against the provider can be mailed to the Privacy Officer by sending it to:

Youjeong Kim, M.D.
1236 Sutter Street
San Francisco, CA 94109

Attention: Privacy Officer

The Privacy Officer can be contacted by telephone at (415) 775-1095.

XV. Effective Date

This Notice is effective as of August 1, 2015.