Notice Of Privacy Practices

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 are required by law to provide you this notice that explains our privacy practices with regards to your medical information and how we may use and disclose your protected health information for treatment, payment and health care operations, as well as for other purposes that are permitted or required by law. This notice is effective August 7, 2007 and applies to all protected health information as defined by federal regulations. You have certain rights regarding the privacy of your protected health information and we also describe them in this notice.

Each time you visit Temecula Valley Family Physicians a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnosis, treatment, and a plan for future care or treatment this health information is often referred to as your health or medical record.

Ways in which we may use and disclose your protected health information

The following paragraphs describe different ways that we use and disclose your protected health information. We have provided an example for each category, but these examples are not meant to be exhaustive. We assure you that all the ways we are permitted to use and disclose your health information fall within one of these categories.

Treatment: We will use and disclose your protected health information to provide, coordinate or manage your health care and any related services. We will also disclose your health information to other physicians who may be treating you. Additionally we may from time to time disclose your health information to another physician who we have requested to be involved in your care. For example – We would disclose your health information to a specialist to whom we have referred you for a diagnosis to help in your treatment.

Payment: We will use and disclose your protected health information to obtain payment for the health care services we provide you. For example – We may include information with a bill to a third-party payer that identifies you, your diagnosis, procedures performed and supplies used in rendering the service.

Health Care Operations:
We will use and disclose your protected health information to support the business activities of our practice. For example – We may use medical information about you to review and evaluate our treatment and services of to evaluate our staff's performance while caring for you. In addition, we may disclose your health information to third part business associates who perform billing, consulting or transcription services for our practice.

Other ways we may use and disclose your protected health information

Appointment Reminders: We will use and disclose your protected health information to inform you of any upcoming appointments in our office the day before the appointment.

Others Involved in your Care: We will use and disclose your protected health information to a family member, a relative, a close friend or any other person you identify in writing that is involved in your medical care or payment of care.

Research: We will use and disclose your protected health information to researchers provided the research has been approved by an institutional review board that had reviewed the research proposal and established protocols to ensure the privacy of your health information.

As Required By Law: We will use and disclose your protected health information when required to by federal, state or local law. You will be notified of any such disclosures.

To Avert A Serious Threat To Public Health or Safety: We will disclose your protected health information to a public health authority that is permitted to collect or receive the information for purpose of controlling disease, injury or disability. If directed by that health authority we will also disclose your health information to a foreign government agency that is collaborating with that public health authority.

***Worker's Compensation*:** We will use and disclose your protected health information for worker's compensation or similar programs that provide benefits for work-related injuries or illness.

***Inmates*:** We will use and disclose your protected health information to a correctional institution or law enforcement official if you are an inmate of that correctional institution or under the custody of law enforcement official. This information would be necessary for the institution to provide you with health care; to protect the health and safety and security of the correctional institution.

Your Health information Rights

Although your health record is the physical property of the health care practitioner of facility that compiled it, the information belongs to you. You have the right to:

A Paper Copy Of This Notice: you have the right to receive a paper copy of this notice upon request. You may obtain a copy by asking our office staff at your next visit or by calling and asking us to mail you a copy.

Inspect And Copy: You have the right to inspect and copy your protected health information that we maintain about you in our designated record set for as long as we maintain that information. This designated record set includes your medical and billing records, as well as any other records we use for making decisions about you. Any psychotherapy notes that may have been included in records we received about you are not available for your inspection or copying by law. We may charge you for the cost of copying, mailing or other supplies used in fulfilling your request. If you wish to inspect a copy of your medical information, you must submit your request in writing to:

Temecula Valley Family Physicians, Inc.
31720 Temecula Valley Parkway Suite 203
Temecula, CA 92592

You may mail in your request or bring it to our office. We will have 30 days to respond to your request for information that we maintain at our practice site. If the information is stored off-site, we are allowed up to 60 days to respond, but must inform you of this delay.

Request Amendment: You have the right to request that we amend your medical information if you feel that it is incomplete or inaccurate. You must make this request in writing, stating exactly what information is incomplete or inaccurate and your reasoning that supports your request. We are permitted to deny your request if it is not in writing or does not include a reason to support the request. We may also deny your request if: the information was not created by us or the person who created it is no longer available to make the amendment, the information is not part of the record which you are permitted to inspect and copy, the information is not part of the designated record set kept by this practice, or if it is the opinion of the health care provider that the information is accurate and complete.

Request Restrictions: you have the right to request a restriction or limitation of how we use or disclose your medical information for treatment, payment or health care operations. For example – you could request that we not disclose information about a prior treatment to a family member or friend who may be involved in your medical care or payment of care. Your request must be in writing. We are not required to agree to your request if we feel it is in your best interest to use or disclose that information. However if we do agree, we will comply with your request unless that information is needed for emergency treatment.

An Accounting of Disclosures: You have the right to request a list of the disclosures of your health information we have made outside of our practice that were not for treatment payment of health care operations. Your request must be made in writing and must state the time period of the requested information. You may not request information for any date prior to April 14, 2003 (the compliance date for the Federal Regulation) nor for a period of time greater than six years (our legal obligation to retain information). Your first request for a list of disclosures within a 12-month period will be free. If you request an additional list within 12 months of the first request, we may charge you for a fee for the costs of providing the subsequent list. We will notify you of such cost and afford you the opportunity to withdraw your request before any costs are incurred.

Request Confidential Communications: You have the right to request how we communicate with you to preserve your privacy. For example – you may request that we call you only at your work number or by mail at a special address or postal box. Your request must be made in writing and must specify how or where we are to contact you. We will accommodate all reasonable requests.

File a Complaint: If you believe we have violated your medical information privacy rights, you have the right to file a complaint with our practice directly to the Secretary of the United States Department of Health and Human Services. To file a complaint with our practice, you must make it in writing within 180 days of the suspected violation. Provide as much detail as you can, about the suspected violation and sent it to:

Temecula Valley Family Physicians, Inc.
31720 Temecula Valley Parkway Suite 203
Temecula, CA 92952

You should know that there would be no retaliation for your filing a complaint.

Use or Disclosures Not Covered: Uses or disclosures of your health information, not covered by this notice of the laws that apply to us, may only be made with your written authorization. You may revoke such authorization in writing at any time and we will no longer disclose health information about you for the reasons stated in your written authorization. Uses and disclosures prior to the revocation are not affected by the revocation.

For More information: if you have questions about this notice or would like additional information, you may contact the Practice Administrator at (951) 302-4700.

Registration Form

ACCOUNT # _____

Please complete so we may update your file

PATIENT INFORMATION

Patient's last name:	First:	Middle Initial:	☐Mr. ☐Mrs.	☐Miss ☐Ms.	Marital status (circle one) ☐ Single / ☐ Mar / ☐ Div / ☐ Sep / ☐ Wid	
E-Mail Address: This is for online health information access.	**Preferred** Contact Number: CELL / HOME / BUSINESS ( )	Birth date: *(mm/dd/yyyy)* / /	Age:	Sex: ☐ M ☐ F		
Street address:	Patient's Social Security no.: (required for online health information access) (###--##--####) – –	Alternate Phone : CELL / HOME /BUSINESS ( )				
P.O. box:	City:	State:	ZIP Code:			
Occupation:	Employer:	Employer phone no.: ( )				
Race:	Preferred Language:	Ethnicity:				
Chose clinic because/ Referred to clinic by (please check one box):	☐Dr.	☐Insurance Plan	☐Hospital			
☐Family	☐Friend	☐Close to home/work	☐Internet	☐Other--		

INSURANCE INFORMATION

(Please give your insurance card and I.D Card to the receptionist.)

Person responsible for bill:	Birth date: *(mm/dd/yyyy)* / /	Address (if different):	Phone no.: ( )		
Subscriber's name:	Sponsor's/Subscriber's S.S. no.: (###--##--####) – --	Birth date: *(mm/dd/yyyy)* / /	Group no.:	Policy no.:	Co-payment: $
Patient's relationship to subscriber:	☐Self	☐Spouse	☐Child	☐Other--	

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Preferred phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Temecula family Physicians Inc. or insurance company to release any information required to process my claims.

I hereby do voluntary consent to such care including routine procedures and other treatments by Temecula Valley Family Physicians professionals and their assigns, appointees or consultants as in necessary in their judgment.

I am aware that the practices of medicine, surgery, and other health discipline do not constitute exact sciences. I acknowledge that no guarantee has been made to me as a result of treatments or examinations in the Temecula Valley family Inc. offices.

Patient/Guardian signature: **Date:**

Office Financial Policy

Payment is expected at time services are rendered. Please remember that payment is your responsibility regardless of insurance.

- All co-pays are due at the time of your office visit.
- If you are a Medicare beneficiary, Medicare will be billed for you. You will be responsible for deductibles, all non-covered services, etc., according to the Medicare guidelines. We must have a copy of your Medicare and any secondary insurance you may have at each visit.
- Please note that certain insurance carrier's routine exams and preventative care are not covered services.
- If Temecula Valley Family Physicians, Inc. is contracted with your insurance company, we will bill for you. If we receive notification that you are not eligible for coverage, you will be responsible for all charges incurred.
- For PPO and Private Insurance, we must have a copy of your insurance card(s) each visit.
- Please be advised Temecula Valley Family Physicians does not bill third party claims.
- Amounts over 60 days past due by an insurance company immediately become the responsibility of the patient. Amounts over 90 days past due are subject to collection procedures, which could include small claims court or a service charge of 1 ½ times the unpaid balance per month.
- If at any time you should experience financial hardship, please notify any of Temecula Valley Family Physicians, Inc. office staff. We are willing to make special arrangements for patients who need extra help.

Authorization to Release Information for Insurance Purposes:

- I hereby authorize my physician to release any information acquired in the course of my examination/treatment.
- I authorize my physician to initiate a complaint to the Insurance Commissioner for any medical reason on my behalf.
- I have read and understand the above statements.
- I agree to comply with the financial policies of this office and I take financial responsibility for my account.

Signature_____ **Date:** _____

Insurance Assignments

I hereby authorize payment of benefits to be made to Temecula Valley Family Physicians, Inc. (Curtiss W. Combs, M.D.) for services provided to me by Temecula Valley Family Physicians, Inc. I understand that I am financially responsible to Temecula Valley Family Physicians, Inc. for charges not covered by this assignment. This authorization will remain in effect until revoked by the undersigned.

Financial Disclosure Statement

The Financial Disclosure Statement is in compliance with the Federal Truth-In-Lending Act. You may pay your entire balance at any time. You are responsible for payment on your account regardless of your insurance. Temecula Valley Family Physicians, Inc. cannot accept the responsibility for collecting your claims or negotiating a settlement on a disputed claim. Temecula Valley Family Physicians, Inc. will not acquire or retain any security interests in any property to secure the payment of credit extended for the services. However, Temecula Valley Family Physicians, Inc. reserves the right to obtain assignments for payment of the balances accrued at the group. I certify that I have read this statement and have had an opportunity to review with the group personnel any questions that I may have regarding the statement.

Patient's
Signature:_____Date:_____
(If minor, signature of responsible person/party required.)

Internal Office Use Only: If patient or patient's representative refuses to sign acknowledgment of receipt of this notice, please document the date and time the notice was presented to patient and sign below.

Presented on: (Date and Time) _____ **By: (Name/Title)**_____

New Patient Consent to the Use and Disclosure of Health Information For Treatment, Payment, or Healthcare Operations

I, _____ , understand that, as a part of my healthcare, Temecula Valley Family Physicians, Inc. originates and maintains paper and/or electronic records describing my health history, symptoms, examinations, test results, diagnosis, treatment, and plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many health professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I have been provided with a Notice of Information Policies that provides a more complete description of information, uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent.
- The right to object to the use of my health information for directory purposes.
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

I understand that Temecula Valley Family Physicians, Inc. is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that refusing to sign this consent, this organization may reuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Temecula Valley Family Physicians, Inc. reserves the right to changes its notice and practices. Prior to implementation of the change, in accordance with Section 164.520 of the Code of Federal Regulations, Temecula Valley Family Physicians, Inc. upon request will send a copy of the revised notice to the address I have provided (either U.S. mail or, if I agree, via email).

I wish to have the following restrictions regarding the use or disclosure of my health information:

_____

_____

I understand that as a part of this organization's treatment, payment or healthcare operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept the terms of this consent.

_____ _____

(Patient Signature) (Date)

If you understand and decline the terms of this consent, please see the receptionist.

ADVANCE DIRECTIVE STATUS

I have been informed of my right to formulate an Advance Directive and I have been provided with information regarding the execution of an Advance Directive.

Please check one of the following:

☐ I have previously completed an Advance Directive and have provided a copy for inclusion in my record.

☐ A copy of my Advance Directive is on file with _____.
(Physician or healthcare facility)

☐ I have not executed an Advance Directive and I am not interested in any further information.

☐ I am interested in the formulation of an Advance Directive and will discuss my options with my primary care provider.

_____ _____
Patient's Signature Date

Comments:
_____
_____
_____
_____
_____

[ ] The patient was given a brochure/information on Advance Directives.

_____ _____
Staff's Signature Date

Patient Name:	DOB:

Temecula Valley Family Physicians, Inc.

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent to Temecula Valley Family Physicians, Inc./Dr. Curtiss W. Combs practice to use and disclose protected health information about me to carry out treatment, payment and healthcare operations. Temecula Valley Family Physicians' *Notice of Privacy Practices* provides me a more complete description of such uses and disclosures.

I have received the *Notices of Privacy Practices* prior to signing this consent form. I understand Temecula Valley Family Physicians, Inc. /Dr. Curtiss W. Combs' practice reserves the right to revise its *Notice of Privacy Practices* at any time. The Privacy Rule allows covered health care providers to communicate electronically, such as through e-mail, with their patients, provided they apply reasonable safeguards when doing so. See 45 C.F.R § 164.530 ©. I may obtain a revised version by forwarding a written request to:

Temecula Valley Family Physicians, Inc. Privacy Officer
31720 Temecula Parkway Suite #203
Temecula, California 92592
Tel 951-302-4700 Fax 951-302-4701

Patient's Initials: _____

With this consent, I give my permission for Temecula Valley Family Physicians, Inc./Dr. Curtiss W. Combs to: (initial applicable boxes)

☐ Call my home or other alternative location and leave a message on voice mail, answering machine, or in person, in reference to any information that assists the practice in carrying out treatment, payment, and healthcare operations to include, but not limited to appointment reminders, insurance concerns/questions, and calls pertaining to my clinical care to include, but not limited to laboratory results.

☐ Mail to my home or other electronic means (e-mail or fax) any information that assists the practice in carrying out treatment, payment, or healthcare information. Covered entities are not responsible for unauthorized access of protected health information while I transmission to the individual based on the individual request. Further covered entities are not responsible for safeguarding information once delivered to the individual.

☐ Communicates by telephone or in writing any information that assists the practice in carrying out treatment, payment, or healthcare information with my spouse, family member or other representative that I have indicated below: **Please specify person's FIRST & LAST NAME AND RELATIONSHIP TO PATIENT.**

Your e-mail: _____

I have the right to request that Temecula Valley Family Physicians, Inc./Dr. Curtiss W. Combs' practice restrict how it uses or discloses my protected healthcare information to carry out treatment, payment, and/or healthcare operations. I may revoke my consent in writing, except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent or later revoke it, Temecula Valley Family Physicians, inc./Dr. Curtiss W. Combs' practice may decline to provide me treatment to me.

_____ _____

(Print Patient Name) (Signature of Patient or Guardian)

Date: _____ Date of Birth: _____ Chart Number: _____

31720 Temecula Parkway #203
Temecula, CA 92592
❖
3989 W. Stetson Ave #100
Hemet, CA 92545
❖
126 Avocado Ave #206
Perris, CA 92571

PATIENT TERMINATION POLICY

Temecula Valley Family Physicians strive to create a pleasant working environment. We understand that there are times when you may be frustrated due to your current symptom(s) or personal situation(s). We will make every attempt to help you. However, this practice, under no circumstances, will tolerate:

- Threatening behavior of any kind including, but not limited to intimidation, verbal abuse, or physical abuse.
- Repeated failed appointments
- Failure to follow Provider orders including, but not limited to, labs, radiology, referrals
- Failure to proceed to the emergency room as directed by a provider
- Leaving a hospital, skilled nursing facility, or other inpatient facility against medical advice
- Failure to follow prescription medication orders or discontinuing of medications without the notification and discussion with Temecula Valley Family Physicians Provider(s).
- Divorce from referred specialist offices
- Break down in patient provider relationship

Any violation of the above stated circumstances are grounds for immediate divorce from Temecula Valley Family Physicians. Due to risks in objectivity in care, all family members of the discharged will also be divorced from the practice.

Curtiss W. Combs, M.D.

By signing below, I acknowledge that I have read and understand the above information.
Print Patient Name: _____ Date: _____
Legal Representative (if applicable):_____
Relationship to patient, If other than self: _____
Patient or Legal Representative Signature: _____

Authorization for Release of Protected Health Information

I authorize Dr. Curtiss W. Combs, Temecula Valley Family Physicians, to request health information **FROM:**

_____

(Specify facility name/title of person to receive information)

_____

(Street Address, City, State, Zip Code)

_____

(Area Code, Telephone Number, Extension, Fax number)

Information To Be Released:

Billing Statements	History & Physical Exams	Outpatient Clinic Reports
Consultations/Evaluations	HIV/AIDS Test Results	Pathology Reports
Discharge Summary	Laboratory Reports	Progress Reports
Entire Medical Record	Operative Reports	Radiology Diagnostic Images/Reports

The Purpose Of This Release Is (Check One Or More):

Continuing Care	Inspection of records	Insurance Claim
Legal Matters	Personal Copy	Second Copy

Other (Please Specify): _____

NOTICE

I understand that information disclosed pursuant to this authorization could be re-disclosed by the recipient. Such re-disclosure is in some cases not protected by California law and may no longer be protected by federal confidentiality law (HIPAA). The recipient of this information is requested not to re-disclose this information without my authorization for disclosure. Temecula Valley Family Physicians/affiliates, its employees, officers and physicians are hereby release from any legal responsibility or liability for improper re-disclosure of the above information to the extent indicated and authorized herein.

My Rights:

* I understand this authorization is voluntary. Treatment, payment, enrollment, or eligibility for benefits may not be conditioned on signing this authorization ***except*** if the authorization is for: 1) conducting research-related treatment, 2) to obtain information in connection with eligibility with enrollment in a health plan, 3) to determine an entity's obligation to pay a claim, or 4) to create health information to provide to a third party.
* I may revoke this authorization at any time, provided that I do so in writing, and submit it to:

Curtiss W. Combs, M.D.
Temecula Valley Family Physicians
31720 Temecula Parkway Suite # 203,
Temecula, CA 92592
Tel 951-302-4700 Fax 951-302-4701

* This revocation will take effect when Dr. Curtiss W. Combs, Temecula Valley Family Physicians, receives it, except to the extent that Dr. Curtiss W. Combs, Temecula Valley Family Physicians has already relied on it. This authorization will automatically expire six months from the date of execution unless otherwise noted.
* I am entitled to receive a copy of it. I understand that the health information may include information related to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental services, and treatment for alcohol and drug abuse.

_____

Print Full Name Relationship to Patient, If Other Than Self

_____

Date of Birth

_____

Signature of Patient or Patient's Legal Representative Date and Time

*****PLEASE DO NOT FAX RECORDS BEFORE 5PM UNLESS NOTED.**
THANK YOU***

FORM 3-1

ADVANCE HEALTH CARE DIRECTIVE

INSTRUCTIONS

Part 1 of this form lets you name another individual as agent to make health care decisions for you if you become incapable of making your own decisions, or if you want someone else to make those decisions for you now even though you are still capable. You may also name an alternate agent to act for you if your first choice is not willing, able, or reasonably available to make decisions for you.

Your agent may not be an operator or employee of a community care facility or a residential care facility where you are receiving care, or your supervising health care provider or an employee of the health care institution where you are receiving care, unless your agent is related to you or is a coworker.

Unless you state otherwise in this form, your agent will have the right to:

1. Consent or refuse consent to any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect a physical or mental condition.

2. Select or discharge health care providers and institutions.

3. Approve or disapprove diagnostic tests, surgical procedures, and programs of medication.

4. Direct the provision, withholding, or withdrawal of artificial nutrition and hydration and all other forms of health care, including cardiopulmonary resuscitation.

5. Donate organs or tissues, authorize an autopsy, and direct disposition of remains.

However, your agent will not be able to commit you to a mental health facility, or consent to convulsive treatment, psychosurgery, sterilization or abortion for you.

Part 2 of this form lets you give specific instructions about any aspect of your health care, whether or not you appoint an agent. Choices are provided for you to express your wishes regarding the provision, withholding, or withdrawal of treatment to keep you alive, as well as the provision of pain relief. You also can add to the choices you have made or write down any additional wishes. If you are satisfied to allow your agent to determine what is best for you in making end of life decisions, you need not fill out Part 2 of this form.

Give a copy of the signed and completed form to your physician, to any other health care providers you may have, to any health care institution at which you are receiving care, and to any health care agents you have named. You should talk to the person you have named as agent to make sure that he or she understands your wishes and is willing to take the responsibility.

You have the right to revoke this advance health care directive or replace this form at any time.

PART 1 – POWER OF ATTORNEY FOR HEALTH CARE

DESIGNATION OF AGENT:

I designate the following individual as my agent to make health care decisions for me:

Name of individual you choose as agent:_____

Address:_____

_____

Telephone: _____

(home phone) *(work phone)* *(cell/pager)*

OPTIONAL: If I revoke my agent's authority or if my agent is not willing, able, or reasonably available to make a health care decision for me, I designate as my first alternate agent:

Name of individual you choose as first alternate agent:_____

Address:_____

Telephone:_____

(home phone) *(work phone)* *(cell/pager)*

OPTIONAL: If I revoke the authority of my agent and first alternate agent or if neither is willing, able, or reasonably available to make a health care decision for me, I designate as my second alternate agent:

Name of individual you choose as second alternate agent:_____

Address:_____

Telephone:_____

(home phone) *(work phone)* *(cell/pager)*

AGENT'S AUTHORITY:

My agent is authorized to make all health care decisions for me, including decisions to provide, withhold, or withdraw artificial nutrition and hydration and all other forms of health care to keep me alive, except as I state here:

_____

_____

_____

_____

(Add additional sheets if needed.)

(3/08)

WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE:

My agent's authority becomes effective when my primary physician determines that I am unable to make my own health care decisions.

_____

(Initial here)

OR

My agent's authority to make health care decisions for me takes effect immediately.

_____

(Initial here)

AGENT'S OBLIGATION:

My agent shall make health care decisions for me in accordance with this power of attorney for health care, any instructions I give in Part 2 of this form, and my other wishes to the extent known to my agent. To the extent my wishes are unknown, my agent shall make health care decisions for me in accordance with what my agent determines to be in my best interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent.

AGENT'S POSTDEATH AUTHORITY:

My agent is authorized to make anatomical gifts, authorize an autopsy and direct disposition of my remains, except as I state here or in Part 3 of this form:

_____

_____

_____

(Add additional sheets if needed.)

NOMINATION OF CONSERVATOR:

If a conservator of my person needs to be appointed for me by a court, I nominate the agent designated in this form. If that agent is not willing, able or reasonably available to act as conservator, I nominate the alternate agents whom I have named, in the order designated.

PART 2 – INSTRUCTIONS FOR HEALTH CARE

If you fill out this part of the form, you may strike any wording you do not want.

END OF LIFE DECISIONS:

I direct that my health care providers and others involved in my care provide, withhold, or withdraw treatment in accordance with the choice I have marked below:

Choice Not To Prolong Life:

_____

(Initial here)

I do not want my life to be prolonged if (1) I have an incurable and irreversible condition that will result in my death within a relatively short time, (2) I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness, or (3) the likely risks and burdens of treatment would outweigh the expected benefits,

OR

Choice To Prolong Life:

_____

(Initial here)

I want my life to be prolonged as long as possible within the limits of generally accepted health care standards.

RELIEF FROM PAIN:

Except as I state in the following space, I direct that treatment for alleviation of pain or discomfort be provided at all times, even if it hastens my death:

_____

_____

_____

(Add additional sheets if needed.)

OTHER WISHES:

(If you do not agree with any of the optional choices above and wish to write your own, or if you wish to add to the instructions you have given above, you may do so here.) I direct that:

_____

_____

_____

(Add additional sheets if needed.)

PART 3 – DONATION OF ORGANS AT DEATH (OPTIONAL)

I. Upon my death:

I give any needed organs, tissues, or parts _____

(Initial here)

OR

I give the following organs, tissues, or parts only: _____

_____

_____

(Initial here)

II. If you wish to donate organs, tissues, or parts, you must complete II. and III.

My gift is for the following purposes:

Transplant: _____ Research: _____

(Initial here) *(Initial here)*

Therapy:_____ Education:_____

(Initial here) *(Initial here)*

III. I understand that tissue banks work with both nonprofit and for-profit tissue processors and distributors. It is possible that donated skin may be used for cosmetic or reconstructive surgery purposes. It is possible that donated tissue may be used for transplants outside of the United States.

1. My donated skin may be used for cosmetic surgery purposes.

Yes_____ No _____

(Initial here) (Initial here)

2. My donated tissue may be used for applications outside of the United States.

Yes_____ No _____

(Initial here) (Initial here)

3. My donated tissue may be used by for-profit tissue processors and distributors.

Yes_____ No _____

(Initial here) (Initial here)

(Health and Safety Code Section 7158.3)

PART 4 – PRIMARY PHYSICIAN (OPTIONAL)

I designate the following physician as my primary physician:

Name of Physician: _____

Telephone: _____

Address: _____

_____

OPTIONAL: If the physician I have designated above is not willing, able, or reasonably available to act as my primary physician, I designate the following physician as my primary physician:

Name of Physician: _____

Telephone: _____

Address: _____

_____

PART 5 – SIGNATURE

The form must be signed by you and by two qualified witnesses, or acknowledged before a notary public.

SIGNATURE:

Sign and date the form here

Date: _____ Time: _____AM / PM

Signature: _____

(patient)

Print name: _____

(patient)

Address: _____

_____

STATEMENT OF WITNESSES:

I declare under penalty of perjury under the laws of California (1) that the individual who signed or acknowledged this advance health care directive is personally known to me, or that the individual's identity was proven to me by convincing evidence, (2) that the individual signed or acknowledged this advance directive in my presence, (3) that the individual appears to be of sound mind and under no duress, fraud, or undue influence, (4) that I am not a person appointed as agent by this advance directive, and (5) that I am not the individual's health care provider, an employee of the individual's health care provider, the operator of a community care facility, an employee of an operator of a community care facility, the operator of a residential care facility for the elderly, nor an employee of an operator of a residential care facility for the elderly.

FIRST WITNESS

Name:_____ Telephone: _____

Address: _____

_____

Date:_____ Time:_____ AM / PM

Signature: _____

(witness)

Print name: _____

(witness)

SECOND WITNESS

Name: _____Telephone: _____

Address: _____

_____

Date: _____Time: _____AM / PM

Signature: _____

(witness)

Print name: _____

(witness)

ADDITIONAL STATEMENT OF WITNESSES:

At least one of the above witnesses must also sign the following declaration:

I further declare under penalty of perjury under the laws of California that I am not related to the individual executing this advance health care directive by blood, marriage, or adoption, and to the best of my knowledge, I am not entitled to any part of the individual's estate upon his or her death under a will now existing or by operation of law.

Date: _____Time: _____AM / PM

Signature: _____

(witness)

Print name: _____

(witness)

YOU MAY USE THIS CERTIFICATE OF ACKNOWLEDGMENT BEFORE A NOTARY PUBLIC INSTEAD OF THE STATEMENT OF WITNESSES.

State of California

County of _____)

On *(date)* _____ before me, *(name and title of the officer)* _____
personally appeared *(name(s) of signer(s))* _____, who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.
I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal. [Civil Code Section 1189]

Signature: _____[Seal]

(notary)

PART 6—SPECIAL WITNESS REQUIREMENT

If you are a patient in a skilled nursing facility, the patient advocate or ombudsman must sign the following statement:

STATEMENT OF PATIENT ADVOCATE OR OMBUDSMAN

I declare under penalty of perjury under the laws of California that I am a patient advocate or ombudsman as designated by the State Department of Aging and that I am serving as a witness as required by Section 4675 of the Probate Code.

Date: _____Time: _____AM / PM

Signature: _____

(patient advocate or ombudsman)

Print name: _____

(patient advocate or ombudsman)

Address: _____

_____

Inland Empire Health Plan

Authorization for Use and/of Disclosure of Patient Health Information

Completion of this document authorizes the use and/or disclosure of your health information. Please read the entire document (both pages) before signing.

Patient Name: _____ Date of Birth: _____
Patient Address: _____

I hereby authorize:	**To release information (*specified below*) to:**
Curtiss W. Combs (Health Care Provider/Organization to **release** information)	_____ (Health Care Provider/Organization to **receive** information)
31720 Temecula Parkway (Address)	_____ (Address)
Temecula, Ca 92562 (City, state, zip code)	_____ (City, state, zip code)
(951) 302-4700 **(951) 302-4701** (Phone number) (Fax number)	_____ (Phone number) (Fax number)

I authorize the release of the following health information (*select only one of the following*):

☐ All health information about my medical history, mental or physical condition and treatment received; OR

☐ Only the following records or types of health information (including any dates:
_____
_____

NOTE: The following types of information will NOT be released unless specifically authorized.

I specifically authorize the release of the following health information (initials *required if any of the following boxes are checked)*

☐ Mental health treatment information Initial: _____

☐ HIV test results Initial: _____

☐ Alcohol / drug treatment information Initial: _____

Authorization for Use and/or Disclosure of Patient Health Information

A separate authorization is required to authorize the disclosure or use of psychotherapy notes.
PURPOSE: The requested use or disclosure of my health information is the following purposes:
(1) To provide and coordinate my health care treatment and services: and
(2) To improve the quality of health care that I receive.

EXPIRATION: This authorization expires one year from the date of my signature unless a different date if specified here: _____ (*date*).

REVOCATION: I understand that I may cancel this authorization at any time, but must do so by submitting my request for revocation to the Health Care Provider / Organization authorized to release the information. My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this authorization.

NOTICE OF RIGHTS AND OTHER INFORMATION:

I understand that I do not have to sign this authorization. My refusal will not affect my ability to obtain treatment, payment or eligibility for benefits.

I understand that I have the right to receive a copy of this authorization.

I further understand that information disclosed by this authorization, may be redisclosed (given to) another person or agency and may no longer be protected by federal confidentiality law (HIPAA). However, California law does not allow the person receiving my health information by this authorization to disclose it, unless a new authorization for such disclosure is obtained from me or unless such disclosure is specifically required or permitted by law.

I have read both pages of this authorization and agree to the use and disclosure of health information specified above.

_____ _____
Signature of Patient Date signed

_____ _____
Signature of Patient's Legal Representative (if applicable) Date signed

_____ _____
Print Name of Patient's Legal Representative Relationship to patient

Temecula Valley
Family Physicians
Curtiss W. Combs, M.D.

CONSENT FOR MINORS In California, a minor is defined as a person under the age of 18 years. Generally, minors may not consent for medical diagnosis or treatment. There are, however, situations for which they may consent. Whether adult or minor, the consenting individual must be provided with informed consent and that discussion, by the licensed healthcare provider, must be documented in the medical record.

WHO MAY GRANT CONSENT FOR A MINOR? California law authorizes the parent(s) or legal guardian of a minor child to give consent for most medical decisions on behalf of the minor. Other special consent situations are as follows:

- A “qualified adult relative” may grant consent if the minor lives with that adult. A “qualified adult relative,” is defined as an adult spouse, parent, stepparent, brother, sister, stepbrother, stepsister, half-brother, half-sister, uncle, aunt, niece, nephew, first cousin, or any person denoted by the prefix “grand” or “great,” or the spouse of any of those persons. A specific authorization form is required.
- “Court assigned guardians” may consent for a minor's medical care as defined by the documents awarding guardianship.
- In “divorce/separation” situations, a parent with legal custody may give consent. If both parents have legal custody, and there is no disagreement, either parent may give consent and have access to information / records.
- “Foster parents” may consent to "ordinary" medical care such as immunizations, physical exams, or x-rays if placement was by court order or with consent of the child's legal custodians. Foster parents may NOT give consent for surgical or experimental/controversial treatments/medications.
- “Stepparents” generally do not have the authority to give legal consent for medical treatment of a minor child. However, there are several exceptions to this rule.

    1. A stepparent may give consent for a minor’s medical care if the stepparent has legally adopted the child or has been designated as the child’s legal guardian or

    2. A stepparent may authorize medical care for the minor by completing and signing a “Caregiver’s Authorized Affidavit”. This authorization is valid only if the following exist:

- The minor is living with the qualified relative, such as a stepparent • The stepparent must advise the parents of the proposed medical treatment and have received no objection OR they have been unable to contact the parents.

OTHER AREAS WHEN MINORS MAY GIVE CONSENT

- Minors may consent to most types of health care treatment who are married or divorced, on active duty with the U.S. Armed Forces, emancipated by a court order, or self-sufficient 15 years or older, living away from home, and managing his own finances).

ACCESS TO THE MINOR'S MEDICAL RECORD Parents or legal guardians usually have a legal right to obtain a minor child's medical records.

- However, in circumstances where a minor can consent to medical treatment, the healthcare provider can only share the minor's medical records with the parents with the signed consent of the minor. For example, a parent can access minor medical records for treatment of the flu or a laceration, but not for treatment of an STD or pregnancy.
- The health care provider may also limit parental access to the minor's record if the provider feels it is detrimental to the provider's relationship with the minor.

Temecula Valley
Family Physicians
Curtiss W. Combs, M.D.

ATTN: PPO PATIENTS

Office/sick visit: Any direct personal exchange between an ambulatory patient and a physician or members of their staff for the purpose of seeking care and rendering health services.

At your initial establish care visit, a full history is taken, chronic conditions and any other concerns you may have will be addressed. In addition, and if needed, a laboratory requisition will be issued. This service is billed as an office visit. At this initial office visit, a physical/wellness exam will be scheduled for a later date.

Preventive visit: A yearly appointment intended to prevent illnesses and detect health concerns before symptoms are noticeable. This visit generally includes a complete physical exam.

The physical/wellness visits are considered preventative services often covered annually by your insurance**. If you wish to discuss medical concerns or the provider observes an abnormal finding of any kind, the finding will take precedence over the preventative care visit, and that appointment will change to an office/sick visit for which copays and deductibles may apply and will be patient responsibility.** In addition, any orders recommended during the visit may require a scheduled follow-up appointment. The physical/wellness visit will be deferred /rescheduled to a later date.

If you have any questions regarding the above information, please do not hesitate to ask an office or billing manager for further assistance.

Temecula Valley
Family Physicians
Curtiss W. Combs, M.D.

31720 Temecula Parkway #203
Temecula CA 92592
951. 302. 4700
951. 302. 4701 Fax
www.DrCombs.com

June 2024

Dear Patients,

As of August 29, 2017 the CDC recommends Schedule 2 drugs such as Hydrocodone, Oxycodone, Morphine, and others be administered only to patients with cancer, other terminal illnesses, and two weeks post-operative procedures. Acute conditions may be treated with Schedule 2 medications for 3–7 days, and chronic pain conditions will be treated with **Non-opiate alternatives** or Schedule 3 medications.

Since 2023, all of our providers have long agreed to dispense Schedule 2 medications in accordance with the CDC guidelines. Therefore, our office will no longer fill long-term use of Schedule 2 pain medications unless the above criteria is met for receiving Schedule 2 medications.

We strongly urge you to consider choosing another primary care physician if it is your intent to continue long-term use of Schedule 2 medications.

Your signature below will indicate full understanding of our office's Schedule 2 medication policy.

Patient Signature _____ Date _____

Patient Name (printed)_____

Curtiss W. Combs, MD
Temecula Valley Family Physicians

Temecula Valley Family Physicians, Inc. Privacy Officer
31720 Temecula Parkway Suite #203
Temecula, California 92592
Tel 951-302-4700 Fax 951-302-4701

Patient's Initials: _____

With this consent, I give my permission for Temecula Valley Family Physicians, Inc and Dr. Curtiss W. Combs to **(PLEASE INITIAL ONE OR ALL THE BOXES THAT APPLY):**

[ ] **Call my home** or other **alternative location** and **leave a message on voice mail, answering machine, Texting**, or in person, in reference to any information that assists the practice in carrying out treatment, payment, and healthcare operations to include, but not limited to appointment reminders, insurance concerns/questions, and calls pertaining to my clinical care to include, but not limited to laboratory results.

[ ] **Mail to my home or other alternative location** any information that assists the practice in carrying out treatment, payment, or healthcare operations.

[ ] **Release or communicate** information by **telephone, E-mail, Texting or in writing**, any information that assists the practice in carrying out treatment, payment, or **healthcare information with my spouse, family member or other representative that I have indicated below:**

(IF A FIRST NAME, LAST NAME, AND RELATIONSHIP TO THE PATIENT IS NOT LISTED, ONLY THE PATIENT CAN ACCESS HIS/HER RECORDS. IF YOU LIKE US TO CONTACT YOU THROUGH EMAIL / TEXTING PLEASE LIST YOUR EMAIL CELL NUMBER).

_____

PATIENT'S EMAIL:

I have the right to request that Temecula Valley Family Physicians, Inc./Dr. Curtiss W. Combs' practice restrict how it uses or discloses my protected healthcare information to carry out treatment, payment, and/or healthcare operations. I may revoke my consent in writing, except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent or later revoke it, Temecula Valley Family Physicians, inc./Dr. Curtiss W. Combs' practice may decline to provide me treatment to me.

Date: _____

Patients
Name:_____
_____

Date of Birth: _____

Signature of Patient/ Guardian:
_____