WELCOME TO

TORRANCE MEMORIAL PHYSICIAN NETWORK

Thank you for choosing us as your healthcare provider. We have enclosed instructions for filling out the paperwork that will be necessary for your first visit. Please have **paperwork ready** and bring your **insurance card** and **photo ID**. The first six pages are read only to assist you in filling out the paperwork. The last five pages will need to be filled out and signed to be given to the receptionist when checking in for your appointment.

Title Page

TORRANCE MEMORIAL
PHYSICIAN NETWORK

READ ONLY: Details on RACE and ETHNICITY

Identify Race: We are required by Federal health care programs to request this information as a part of the demographic data they collect. Individuals are asked to indicate one or more races that apply from among the following or you may decline to specify.

American Indian or Alaska Native **Asian** **Black or African American**	**Native Hawaiian or Other Pacific Islander** **White**
Race Categories As Defined by US Federal OMB:	
American Indian or Alaska Native	A person having origins in any of the original peoples of North and South America (including Central America) and who maintains tribal affiliation or community attachment.
Asian	A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
Black or African American	A person having origins in any of the black racial groups of Africa.
Native Hawaiian or Other Pacific Islander	A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands
White	A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

Identify Ethnicity: We are required by Federal health care programs to request this information as a part of the demographic data they collect Individuals are asked to designate their ethnicity from the following or you may decline to specify:

Hispanic or Latino; or	**Not Hispanic or Latino**
Hispanic or Latino Defined	A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish Culture or origin regardless of race.
Unknown	Unknown/Not Reported

LATE CANCELLATION AND NO-SHOW POLICY

Cancellations:

For the convenience of all our patients and staff, Torrance Memorial Physician Network requires one full business day notice whenever you need to cancel an appointment. Getting cancellation information in advance allows the office to schedule and serve other patients.

No Shows:

We understand that things happen and appointments may sometimes not be cancelled in advance. With that in mind, we will forgive a single missed appointment. However, after one miss or late cancellation, you will be charged **$40.00** for each instance. We reserve the right to dismiss patients from Torrance Memorial Physician Network after three missed appointments in a 12-month period.

Torrance Memorial Physician Network firmly believes that a good physician/patient relationship is based upon understanding and good communication. Any questions regarding late cancellation and no-show fees should be directed to the office administrator.

Thank you,
Practice Management

Torrance Memorial Health System Effective Date: 7/20/17

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

Torrance Memorial Health System respects your privacy. We maintain records containing your personal health information that are protected by law. This Notice of Privacy Practices explains how we may use or disclose your protected health information, your rights and our legal duties regarding your protected health information. In this Notice your protected health information is called your "Health Information".

Our Duties Regarding Your Health Information

Torrance Memorial Health System is required by law to maintain the privacy of your Health Information and provide you with this Notice of our legal duties and privacy practices with respect to your Health Information. We reserve the right to change our privacy practices and the terms of this Notice and make the provisions of a revised Notice effective for all your Health Information we maintain. If we revise the Notice we will provide it to you when it is in effect by posting it in a clear and prominent location in our facility, having a copy available for you to request and take with you and posting it on our website if we maintain a website. We must follow the terms of the Notice that is in effect. You may request a copy of the Notice any time and we will give you a copy of the Notice that is in effect when you request it.

You may contact our Privacy Official if you have any questions or would like further information about the matters covered by this Notice. You will find our Privacy Official's contact information at the end of this Notice.

How We May Use and Disclose Your Health Information

Use and Disclosure of Your Health Information for Treatment, Payment and Health Care Operations

We are permitted to use and disclose your Health Information for purposes of treatment, payment and health care operations.

1. **Treatment.** We may use or disclose your Health Information to provide you with health care treatment or services. For example, we may use your Health Information to diagnose and treat you or we may disclose your Health Information to a health care provider you may be referred to so that provider has information needed to diagnose or treat you.
2. **Payment.** We may use or disclose your Health Information to obtain payment or be reimbursed for the health care treatment and services we provide. For example, we may give your Health Information to your health plan so it can reimburse you or pay us. We may also provide your Health Information to your health plan to obtain prior approval for treatment or to determine whether your plan will cover the treatment.
3. **Health Care Operations.** We may use or disclose your Health Information in connection with our health care operations which are ways we provide health care and manage our organization. For example, we may use or disclose your Health Information to evaluate our performance in providing health care to you and identify ways we may improve our service.

Use and Disclosure of Your Health Information *Required or Permitted by Law*

There are situations besides treatment, payment or health care operations where we may use or disclose some of your Health Information without first obtaining your written authorization. Any such use or disclosure will be limited to your Health Information required or permitted by law in the following situations.

1. **Public Health**. We may disclose your Health Information to public health authorities that are authorized by law to collect or receive information to report vital information and prevent or control disease or injury. For example, we

may report information about communicable diseases, child abuse or neglect, problems related to food, medications or medical devices or products and vital events such as births or deaths. We may also disclose your Health Information to a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition or findings concerning a work-related illness or injury or workplace related health issue to an employer. If we reasonably believe you are a victim of abuse, neglect, or domestic violence we may disclose your Health Information limited to requirements of law to a government authority, including a social service or protective services agency, authorized by law to receive reports of such abuse, neglect, or domestic violence.

2. **Health Oversight Activities.** We may disclose your Health Information to a health oversight agency that includes, among others, an agency of the federal or state government authorized by law to monitor the health care system. Authorized health oversight activities include audits; civil, administrative, or criminal investigations; inspections; licensure or disciplinary actions; civil, administrative or other activities necessary for appropriate oversight of the health care system.
3. **Judicial and Administrative Proceedings.** We may disclose your Health Information in the course of judicial or administrative proceedings. For example, we make a disclosure in response to a court or administrative order or subpoena.
4. **Law Enforcement Purposes.** We may disclose your Health Information to a law enforcement official as required by law, in response to a law enforcement official's lawful request to identify or locate a victim, suspect, fugitive, material witness or missing person or to report a crime that has occurred on our premises or that may have caused a need for emergency services.
5. **Required by Law.** We may use or disclose your Health Information when required by state, federal or other law to correctional institutions, the Food and Drug Administration and authorized federal officials for the conduct of lawful national security activities and the provision of protective services to the President or other persons as required by federal law.
6. **Coroners, Medical Examiners and Funeral Directors.** We may disclose your Health Information to coroners or medical examiners to identify a deceased person or to determine the cause of death and to funeral directors as necessary to carry out their duties.
7. **Organ Donation.** We may disclose your Health Information to an organ procurement organization or other facility that participates in or makes a determination for the procurement, banking or transplantation of organs or tissues.
8. **Research.** We may use or disclose your Health Information for research purposes under strict legal protection only if the use or disclosure has been reviewed and approved by a special Privacy Board or Institutional Review Board or if you authorize the use or disclosure.
9. **Disaster Relief Incidents.** We may use or disclose your Health Information to a public or private entity authorized to assist in disaster relief efforts such as the American Red Cross. If you tell us you object, we will not make this use or disclosure unless we must do so to respond to an emergency situation.
10. **Persons Involved in Your Care.** We may use or disclose your Health Information to persons involved in your health care or payment for health care including family members, your personal representative or another person identified by you unless you object to our use and disclosure of your Health Information to such persons.
11. **Workers Compensation.** We may use or disclose your Health Information to comply with worker's compensation laws.
12. **Avert a Serious Threat to Health or Safety.** We may use or disclose your Health Information if we believe it is necessary to prevent or lessen a serious threat to the health or safety of a person or the public.

13. **School Immunization Records.** We may disclose your Health Information to provide proof of your immunization to a school if you are an adult or emancipated minor and you agree; or about a minor child if the child's parent or guardian agrees.
14. **Military.** If you are a member of the armed forces, we may release medical information about you to military authorities as authorized or required by law. We may also release medical information about foreign military personnel to the appropriate foreign military authority.
15. **Business Associates.** We may use entities that are called Business Associates to perform work or services for us such as legal, accounting or financial services where the Business Associate may be required to create, receive, maintain or transmit your Health Information but only if the Business Associate first agrees by written contract to safeguard your Health Information as we must and as is required by law.
16. **Fundraising.** We may use limited Health Information such as your name, address and treatment dates to contact you for fundraising purposes to support our health care purposes and mission. You have the right to elect not to receive fundraising communications and if you receive a fundraising communication from us you will also receive simple instructions about how to stop receiving any more fundraising communications. If you do not want the Foundation to notify you of these opportunities, you must complete the form "**Opt Out of Fundraising**".

Use and Disclosure of Your Health Information *Requiring Written Authorization*

Your written authorization is required for the following uses and disclosures of your Health Information:

1. **Marketing.** We will not use or disclose your Health Information for marketing purposes without your written authorization. Marketing is defined as a communication about a product or service related to your health care for which we receive payment from a third party.
2. **Sale of your Health Information.** We will not use or disclose your Health Information in a way that is considered a sale of your Health Information without your written authorization. A sale of your Health Information is defined as an exchange where we, directly or indirectly, receive payment for your Health Information from the recipient of your Health Information.
3. **Psychotherapy Notes.** If we maintain psychotherapy notes about you we will not disclose psychotherapy notes without your written authorization except in limited instances that are permitted or required by law.

All Other Uses and Disclosures of Your Health Information Require Written Authorization

Your written authorization is required for other uses and disclosures of your Health Information that are not described in this Notice.

You May Revoke an *Authorization in Writing at Any Time*

You may revoke an authorization to use or disclose your Health Information at any time. Your revocation must be in writing and it will not affect uses or disclosures of your Health Information made in reliance on your authorization before its revocation. If the Authorization was obtained as a condition of obtaining insurance coverage, other law may provide the insurer with the right to contest a claim under the policy or the policy itself.

Your Rights Regarding Your Health Information

This section explains your rights and how you can make use of your rights regarding your Health Information.

1. **Your Right to Our Notice of Privacy Practices**

You have the right to obtain a paper copy of our current Notice of Privacy Practices. You have the right to receive an electronic copy of this Notice from our web site if we maintain one or, if you agree in writing, by email. You have the right to obtain a paper copy of this Notice at any time even if you have agreed to receive it electronically. You may ask our Privacy Official whose contact information is at the end of this Notice to provide you with a copy of our current Notice at any time.

2. **Your Right to Request Restrictions of Use and Disclosure of Your Health Information**

A. Your General Right to Request Restrictions - We Are Not Required to Agree

You have the right to request a restriction of your Health Information we use or disclose for your treatment, for payment of your health care services, or for activities related to our health care operations. You may also request a restriction on what Health Information we may disclose to someone who is involved in your care or payment for your care, like a family member or friend. Your request must be in writing and given to our Privacy Official whose contact information is at the end of this Notice. We will provide you with the form to make your written request. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment and we will request that health care provider not to further use or disclose your Health Information. We may terminate our restriction if you ask us to terminate it. We may also terminate a restriction whether or not you ask us to end the restriction if we inform you we are terminating it. If we do terminate a restriction it will only affect your Health Information that was created or received after we inform you of the termination.

B. Your Right to Request We Not Disclose Your Health Information to Your Health Plan (Health Insurance Provider) - We Must Agree Under Certain Conditions

You have the right to request that we not disclose your Health Information to your health plan (your health insurance provider) if the disclosure:

(1) is for the purpose of carrying out payment or health care operations,
(2) is not otherwise required by law, and
(3) pertains solely to a health care item or service for which you or someone other than the health plan on your behalf has paid for in full.

Your request must be in writing and given to our Privacy Official whose contact information is at the end of this Notice. We will provide you with the form to make your written request. We must agree to your request if all three conditions listed above are present.

3. Your Right to Request Confidential Communications

You have the right to request that we communicate with you about your Health Information by alternative means or at an alternative location. For example, you can ask that we only contact you by telephone at work or by mail in a sealed envelope (not a post card). We will not ask you the reason for your request and we will accommodate all reasonable requests. If we are unable to communicate with you by the alternative means or at the alternative location you have requested we may attempt to communicate with you using any information we have. Your request must be in writing and given to our Privacy Official whose contact information is at the end of this Notice. We will provide you with the form to make your written request.

4. Your Right to Inspect and Copy your Health Information

You have the right to inspect and copy your Health Information we maintain that may be used to make decisions about your treatment and care including billing records for as long as we maintain the information. You may also request an electronic copy of your Health information if we maintain it electronically. Your request must be in writing and given to our Privacy Official whose contact information is at the end of this Notice. We will provide you with the form to make your written request and provide access to your Health Information except in some limited circumstances. If we deny any part of your request we will explain in writing why we made the denial, if and how you may request a review of our denial and how you may make a complaint to us and the Secretary of the U.S. Department of Health and Human Services about our denial. We may charge a reasonable, cost-based fee for making copies of your Health Information and sending them to you that includes costs of labor, supplies and postage. We will not charge a fee if you only view and inspect your Health Information at a convenient time and place.

5. **Your Right to Request Amendment of your Health Information**
If you believe your Health Information we maintain is incorrect or incomplete you have the right to request we amend that Health Information. Your request must be in writing and given to our Privacy Official whose contact information is at the end of this Notice. We will provide you with the form to make your written request. We will inform you of our action on your request including what we will do if we accept your request for amendment in whole or in part. If we deny all or part of your request for amendment we will provide you with the reasons for the denial and inform you of your additional rights regarding our denial including your right to complain to us and the Secretary of the U.S. Department of Health and Human Services.
6. **Your Right to an Accounting of Disclosures of your Health Information**
You have the right to receive a list (accounting) of certain disclosures of your Health Information we have made. Your request for an accounting of these disclosures must be in writing and given to our Privacy Official whose contact information is at the end of this Notice. We will provide you with the form to make your written request and we will provide you with the accounting in writing. You may request an accounting of disclosures for up to six (6) years before the date you make the request. We will provide the accounting free of charge. If you request an accounting more once in a twelve (12) month period we may charge you a reasonable, cost-based fee for providing another accounting but first we will let you know what the cost would be so you can modify your request to reduce the fee or withdraw it.
7. **Your Right to Make a Complaint that Your Privacy Rights Have Been Violated**
If you believe your privacy rights have been violated, you have the right to file a complaint with us and with the Secretary of the U.S. Department of Health and Human Services. We will not retaliate against you for filing a complaint that your privacy rights have been violated. You may file a complaint with us by contacting the office of our Privacy Official listed below. Information about making a complaint to the Secretary is provided below.

Contact Information

Torrance Memorial Health System
For more information about the matters covered by this Notice, to make a request about any of your health information rights or to make a complaint that your privacy rights have been violated please contact our Privacy Official listed below. If you wish we will provide you with a form to make a complaint in writing to us. We will not retaliate against you for filing a complaint that your privacy rights have been violated.

Privacy Official of Torrance Memorial Health System
Telephone: (310)784-4953
Office address: 23326 Hawthorne Blvd. Suite 200 Torrance, CA 90505

Secretary, U. S. Department of Health and Human Services

You may make a complaint that your privacy rights have been violated to the Secretary of the U.S. Department of Health and Human Services. We will not retaliate against you for making a complaint to the Secretary that your privacy rights have been violated. The process to make a complaint to the Secretary is explained on the Internet at HHS.gov. A complaint to the Secretary must be filed within 180 days of when you first knew of the reasons you believe your health information privacy rights were violated although the 180-day period may be extended if you can show "good cause."

You may file a Health Information Privacy Complaint with the Secretary online through the OCR Complaint Portal or obtain a Health Information Privacy Complaint Form Package to fill out, print and submit by mail, fax or email.

If you have any questions about filing a complaint you may contact the Department of Health and Human Services, Office for Civil Rights by toll-free telephone at 1-800-368-1019, TDD: 1-800-537-7697.

TORRANCE MEMORIAL PHYSICIAN NETWORK

Patient Registration Form – Adults

For Office Use Only: Visit Date: _____ Initials: _____

Patient Information	Patient's Last Name First Middle Initial			Date of Birth	Sex ☐Male ☐Female
	Race* ☐ White ☐ Black/African American ☐ Asian ☐ American Indian/Alaska Native ☐ Native Hawaiian or Pacific Islander ☐ Decline to answer			Ethnicity* ☐ Hispanic ☐ Non-Hispanic ☐ Decline to answer	
	Marital Status: □Single □Married □Divorced □Separated □Widowed	Primary Language		Primary Care Physician	
	Patient's Street Address Apt. No.			City	State / Zip
	Home Phone ☐check if primary ( )		Cell Phone ☐check if primary ( )		
	Day/Work Phone ☐ check if primary ( )	Alternate Phone ( )		Mother's Maiden Name	
	Patient Employer Name	Employer Address		City / State / Zip	
	Employer Phone ( )			Patient Occupation	
	Employment Status: ☐Not Employed ☐ Full Time ☐Part Time ☐Student ☐Self-Employed ☐Retired date:_____				
	Full Name of Emergency Contact	Relationship	Home Phone ( )	Cell Phone ( )	
Guarantor or person responsible for bill	Patient's Last Name First Middle Initial			Date of Birth	Relationship to Patient
	Street Address Apt. No.				
	City / State / Zip	Home Phone ( )	Work Phone ( )	Cell Phone ( )	
	Employer Name	Employer Address	City / State / Zip		
	Employer Phone ( )	Occupation	Employment Status: ☐ Full Time ☐ Part Time ☐ Retired and Date: _____		
Insurance Information	**Primary Insurance Company**	Subscriber's Full Name		Subscriber's Date of Birth:	
	Subscriber's Employer Name	Relation to Insured	Employment Status: ☐ Full Time ☐ Part Time ☐ Retired Date: _____		
	Subscriber's Employer Address	City / State / Zip		Employer Phone No. ( )	
	Secondary Insurance Company	Subscriber's Full Name	Relation to Insured	Subscriber's Date of Birth:	

Acknowledgement: By signing below I signify that the information I have provided is accurate to the best of my knowledge. This signature also signifies my general consent for treatment to Torrance Health Association DBA Torrance Memorial Physician Network to provide any and all medical treatment to myself or my dependent.

Signature: _____ Date: _____

TORRANCE MEMORIAL
PHYSICIAN NETWORK

DISCLOSURE FORM FOR SHARING AND COMMUNICATION

We may utilize a Patient Portal and/or an Automated Appointment Reminder and Messaging system to allow us to better serve you. (ex. appointment reminders via phone and text, online appointment requests, communicate with office via email, online access to your medical information). There may be some level of risk that information in an email or text message could be read by someone besides you. Please let us know if you do or do not want us to communicate with you by email or text message by completing the following:

☐ Yes – Please communicate with me by secure email through the patient portal. My email address is

_____

I will let you know right away if my email address changes

☐ No – Please do not communicate with me by Email

☐ Yes – Please communicate with me by text message for reminders and surveys. My cell phone number is

_____

I will let you know right away if my cell phone number changes

☐ No – Please do not communicate with me by text message

Disease and Immunization and California Immunization (CAIR) Registries are a computer based tracking systems developed to assist medical providers and other approved agencies to track and review medical information for individuals, to assess needs and avoid redundant immunizations, and control disease outbreaks.

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

By signing this form, you acknowledge receipt of the *Notice of Privacy Practices* of information about how we may use and disclose your protected health information. We encourage you to read it in full.

Our *Notice of Privacy Practices* is subject to change. If we change our notice, you may obtain a copy on our website **www.TMphysiciannetwork.org.** If you have any questions about our *Notice of Privacy Practices* please contact our Privacy Officer at (310) 784-4953 or at tmpnprivacy.officer@tmmc.com

I acknowledge receipt of the *Notice of Privacy Practices* of **Torrance Memorial Physician Network**.

I have been made aware of the above disclosures and understand that complete details are available in the Notice of Privacy Practices I was given. _____ Initials

_____ _____

Name of Patient/Legal Representative *(please print)* Date

_____ _____

Signature of Patient/Legal Representative If Legal Representative, please give relationship

TORRANCE MEMORIAL
PHYSICIAN NETWORK

ASSIGNMENT OF BENEFITS FORM

I hereby assign and convey Torrance Health Association, as my designated authorized representative, all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services. I request that payment of authorized insurance benefits, including Medicare, if I am a Medicare beneficiary, be made on my behalf to Torrance Health Association (THA), DBA Torrance Memorial Physician Network (TMPN) for any equipment or services (i.e., provider visits, treatment, therapy, and/or medications) rendered or provided to me by the organization.

I authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for related equipment or services to the organization, the Centers for Medicare and Medicaid Services (CMS) my insurance carrier or other medical entity. A copy of this authorization will be sent to CMS, my insurance company or other entity if requested. The original authorization will be kept on file by the organization.

I understand and agree:

- That I am financially responsible to the organization for all charges regardless of any applicable insurance or benefit.
- It is my responsibility to notify the organization of any changes in my health care coverage. In some cases exact insurance benefits cannot be determined until the insurance company receives the claim.
- I am responsible for the entire bill or balance of the bill as determined by the organization and/or my health care insurer if the submitted claims or any part of them are denied for payment.

Further, I hereby authorize my plan administrator, fiduciary, insurer, and/or attorney to release to THA/TMPN any and all plan documents, summary benefit description, insurance policy, and/or settlement information upon written request from THA or its attorneys in order to claim such medical benefits.

I understand that by signing this form I am accepting financial responsibility as explained above for all payments on the services I receive.

_____	_____	_____
Patient/Beneficiary Name *(Please print)*	Signature	Date

MEDI-GAP/ MEDICARE SUPPLEMENTAL INSURANCE LIFETIME ASSIGNMENT OF BENEFITS:

I, the undersigned, have Medi-Gap Insurance coverage and assign directly to:

_____ (name of practice or provider), all medical benefit payments on my behalf. I hereby authorize release of medical information necessary to secure benefit payments. I authorize the use of the signature on all insurance submissions whether manual or electronic. This assignment is in effect until revoked by me in writing.

_____	_____	_____
Signature of Beneficiary	Insurance ID Number	Date