INFORMED CONSENT REGARDING EMAIL AND INTERNET USE OF PROTECTED PERSONAL INFORMATION

Angel Longevity Medical Center provides patients with opportunity to communicate with their physician, health care providers and administrative staff. Transmitting confidential health information via email however has a number of risks, both general and specific that should be considered before using email.

1. Risks
    a. General risks: email can be immediately broadcast worldwide and be received by many intended or unintended recipients; recipients can forward it other recipients without original sender permission or knowledge; users can easily misaddress an email; email is easier can be falsify than handwritten or signed documents; backup copies of email may exist after the sender or recipient has deleted his/her copy.
    b. Specific risks: emails containing information pertaining to the diagnosis or treatment must be included in the protected personal health information. All individuals who have access to the protected personal health inform will have access to the email messages; patients who send or receive emails at their place of work risk their employer reading their email.
2. It is the policy of Angel Longevity Medical Center that all email messages sent or received which concern the diagnosis or treatment of a patient will be part of patient's protected personal health information and will treat such email messages with same confidentiality as afforded other portions of protected personal health information. Angel Longevity Medical Center will use reasonable means to protect the security and confidentiality of email or internet communications. Because of the risks involved, we cannot however guaranteed the security and confidentiality of email or internet communication.
3. Patient must consent to the use of email for confidential medical information after having been informed of the above risks. Consent to the use of email includes agreement with the following conditions:
    a. All emails to or from patients concerning diagnosis or treatment will be made a part of the protected personal health information. As a part of the protected personal health information, other individuals such as Angel Longevity Medical Center physician, nurses, other health care professionals, insurance coordinators, and upon written authorization other health care providers and insurers will have access to email messages.
    b. Angel Longevity Medical Center may forward the email within the practice as necessary for diagnosis and treatment. Angel Longevity Medical Center will not, however, forward the email outside the practice without the consent of patient as required by law.
    c. Angel Longevity Medical Center will endeavor to read email promptly but can provide no assurance that the recipient of the particular email will read it promptly. Therefore email must not be used in medical emergency.

d. It is the responsibility of the sender to determine whether intended recipient received the email and when the recipient will respond.
e. Because some medical information is so sensitive that unauthorized disclosure can be very damaging, email should not be used concerning diagnosis or treatment of AIDS/ HIV infection; other sexually transmissible or communicable diseases, such as syphilis, gonorrhea, herpes and the like; Behavioral health, mental health or developmental disability; or alcohol or drug abuse.
f. Angel Longevity Medical Center cannot guarantee that electronic communication will be private. However we will take reasonable steps to protect the confidentiality of email or internet communications but Angel Longevity Medical Center is not liable for improper disclosure of confidential information not caused by its employee's gross negligence or wanton misconduct.
g. If consent is given for use of email, it is the responsibility of patient to inform Angel Longevity Medical Center of any types of information you do not want to be sent by email.
h. It is the responsibility of the patient to protect their password or other means of access to email sent or received from Angel Longevity Medical Center to protect confidentiality. Angel Longevity Medical Center is not responsible for breaches of confidentiality caused by the patient.

Any further use of email initiated by the patient that discusses diagnosis or treatment constitutes informed consent to the foregoing.
I understand that my consent to the use of email can be withdrawn at any time by email or written communication to Angel Longevity Medical Center.
I have read this form carefully and understand the risks and responsibilities associated with the use of email. I agree to assume all risks associated with use of e-mail.

Name Date

Signature :_____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED
AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We must follow the privacy practices as described below. This Notice will take effect on *3/1/2007* and will remain in effect until it is amended or replaced by us.

It is our right to change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date changes were made.

You may request a copy of our Privacy Notice at any time by contacting our Privacy Officer, Angel Medical Center. Information on contacting us can be found at the end of this Notice.

TYPICAL USES AND DISCLOSURES OF HEALTH INFORMATION

We will keep your health information confidential, using it only for the following purposes:

Treatment: **We may use your health information to provide you with our professional services. We have established "minimum necessary or need to know" standards that limit various staff members' access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.**

Disclosure: **We may disclose and/or share your healthcare information with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree that we may do so.**

Payment: **We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations or other businesses that may become involved in the process of mailing statements and/or collecting unpaid balances.**

Emergencies: **We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays or other similar forms of health information and/or supplies unless you have advised us otherwise.**

Healthcare Operations: **We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, outside health or management reviewers and individuals performing similar activities.**

Required by Law**: We may use or disclose your health information when we are required to do so by law. (Court or administrative orders, subpoena, discovery request or other lawful process.) We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.**

Abuse or Neglect: **We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.**

Public Health Responsibilities: **We will disclose your health care information to report problems with products, reactions to medications, product recalls, disease/infection exposure and to prevent and control disease, injury and/or disability.**

Marketing Health-Related Services: **We will not use your health information for marketing purposes unless we have your written authorization to do so.**

National Security: The **health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.**

Appointment Reminders: **We may use or disclose your health information to provide you with appointment reminders, including, but not limited to, voicemail messages, postcards or letters.**

YOUR PRIVACY RIGHTS AS OUR PATIENT

Access: **Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian.) There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact our Privacy Officer for a copy of the Request Form. You may also request access by sending us a letter to the address at the end of this Notice. Once approved, an appointment can be made to review your records. Copies, if requested, will be $1 for each page and the staff time charged will be**
$ ***20)*** **per hour including the time required to locate and copy your health information. If you want the copies mailed to you, postage will also be charged. If you prefer a summary or an explanation of your health information, we will provide it for a fee. Please contact our Privacy Officer for a fee and/or for an explanation of our fee structure.**

Amendment: **You have the right to amend your healthcare information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.**

Non-routine Disclosures: **You have the right to receive a list of non-routine disclosures we have made of your health care information. (When we make a routine disclosure of your information to a professional for treatment and/or payment purposes, we do not keep a record of routine disclosures: therefore these are not available.) You have the right to a list of instances in which we, or our business associates, disclosed information for reasons *other than* treatment, payment or healthcare operations. You can request non-routine disclosures going back 6 years starting on April 14, 2003. Information prior to that date would not have to be released. *(Example: If you request information on May 15, 2004, the disclosure period would start on April 14, 2003 up to May 15, 2004. Disclosures prior to April 14, 2003 do not have to be made available.)***

Restrictions: **You have the right to request that we place additional restrictions on our use or disclosure of your health information. We do not have to agree to these additional restrictions, but if we do, we will abide by our agreement. (Except in emergencies.) Please contact our Privacy Officer if you want to further restrict access to your health care information. This request must be submitted in writing.**

QUESTIONS AND COMPLAINTS

You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. Your complaint should be directed to our Privacy Officer. If you feel we may have violated your privacy rights, or if you disagree with a decision we made regarding your access to your health information, you can complain to us. In writing. Request a Complaint Form from our Privacy Officer. We support your right to the privacy of your information and will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

HOW TO CONTACT US

Practice Name**: Angel Longevity Medical Center**

Privacy Officer**- Duane Anderson**

Telephone: **323-661-7661** **Fax- 323-661-0747**

E-Mail: info@angelmedcenter.com **Address**: 12840 Riverside Dr Suite 402 **Studio City, CA 91607**

Privacy Rule Patient Consent Agreement

Consent to the Use and Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (164.506(a))

I, _____Understand that as part of my health care, Angel Longevity Medical Center, Inc. originates and maintains health records describing my health history, symptoms, examination and test results diagnoses, treatment and any 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 health professionals who may contribute to my health care;
- A source of information for applying my diagnosis and surgical information to my bill;
- A mean by which a third-party payer can verify that services billed were actually provided;
- A tool for routine health care operation such as assessing quality and reviewing the competence of health care professionals;

I have been provided with a copy and understand the ***Notice of Privacy Practices*** that provides a more complete description of information uses and disclosures.

- I have the right to review Angel Longevity Medical Center, Inc. Notice of Information Practice prior to signing this consent;
- That Angel Longevity Medical Center, Inc. reserve the right to change the notice and practices and that prior to implementation will mail a copy of any revised notice to the address I've provided if requested;
- I have the right to object to the use of my health information for directory purposes;
- I have the right to request restrictions as to how my protected health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that Angel Longevity Medical Center, Inc. Is not required by law to agree to the restrictions requested;
- I may revoke this consent in writing at any time, except to the extent that Angel Medical Clinic, Inc. Has already taken action in reliance thereon.

I request the following restrictions to the use or disclosure of my protected health information:

_____ Accepted _____ Denied

Signature of patient or Legal Representative Witness _____

Print Name of Patient of Legal Representative Witness_____

Date: _____

Private Contract Medicare Release

This agreement is between "Anju Mathur", M.D., whose principal place of business is "12840 Riverside Dr. Suite 402 Studio City CA 91607", and

Beneficiary: _____

Who resides at: _____

_____

Medicare ID #: _____

and is a Medicare Part B beneficiary seeking services covered under Medicare Part B pursuant to Section 4507 of the Balanced Budget Act of 1997. The Physician has informed Beneficiary or his/her legal representative that Physician has opted out of the Medicare program effective on August 1, 2001. The physician is not excluded from participating in Medicare Part B under [1128] 1128, [1156] 1156, or [1892] 1892 of the Social Security Act.

Beneficiary or his/her legal representative agrees, understands and expressly acknowledges the following:

Initial

_____ Beneficiary or his/her legal representative accepts full responsibility for payment of the physician's charge for all services furnished by the physician.

_____ Beneficiary or his/her legal representative understands that Medicare limits do not apply to what the physician may charge for items or services furnished by the physician.

_____ Beneficiary or his/her legal representative agrees not to submit a claim to Medicare or to ask the physician to submit a claim to Medicare.

_____ Beneficiary or his/her legal representative understands that Medicare payment will not be made for any items or services furnished by the physician that would have otherwise been covered by Medicare if there was no private contract and a proper Medicare claim had been submitted.

_____ Beneficiary or his/her legal representative enters into this contract with the knowledge that he/she has the right to obtain Medicare-covered items and services from physicians and practitioners who have not opted out of Medicare, and the beneficiary is not compelled to enter into private contracts that apply to other Medicare-covered services furnished by other physicians or practitioners who have not opted out.

_____ Beneficiary or his/her legal representative understands that Medi-Gap plans do not, and that other supplemental plans may elect not to, make payments for items and services not paid for by Medicare.

_____ Beneficiary or his/her legal representative acknowledges that the beneficiary is not currently in an emergency or urgent health care situation.

_____ Beneficiary or his/her legal representative acknowledges that a copy of this contract has been made available to him.

Executed on: _____

By:

_____

Beneficiary or his/her legal representative

And:

_____ Anju Mathur", M.D **Angel Longevity Medical Center**

Consent for Treatment

I hereby consent to and authorize the administration of all emergency and non-emergency diagnostic and therapeutic treatment for me or my minor child that may be necessary in the judgment of the attending physician and/or medical personnel. It is agreed that because of differences in human constitution and response, it is in no way possible to warrant the outcome of such medical care and service.

Patient Signature: _____ Date:_____

Print Name _____

Parent or Legal Guardian _____

Print Name: _____