PRIVACY POLICY STATEMENT

Temecula Valley Family Physicians
31720 Temecula Parkway #203
Temecula, CA 92592

- 3989 W. Stetson Ave #100
  Hemet, CA 92545

- 126 Avocado Ave #206
  Perris, CA 92571

Privacy Office: David Huezo, Office Manager, 951-302-4700

Purpose: The following privacy policy is adopted to ensure that this Physician Practice complies fully with all federal and state privacy protection laws and regulations. Protection of patient privacy is of paramount importance to this organization. Violations of any of these provisions will result in severe disciplinary action including termination of employment and possible referral for criminal prosecution.

Effective Date: This policy updated and effective as of 07/16/2024. It is the policy of this Physician Practice that we will adopt, maintain and comply with our Notice of Privacy Practices, which shall be consistent with HIPAA and California law.

Notice of Privacy Practices: It is the policy of this Physician Practice that a notice of privacy practices must be published, that this notice be provided to all subject individuals at the first patient encounter if possible, and that all uses and disclosures of protected health information be done in accord with this organization's notice of privacy practices. It is the policy of this Physician Practice to post the most current notice of privacy practices in our "waiting room," and to have copies available for distribution at our reception desk.

Assigning Privacy and Security Responsibilities: It is the policy of this Physician Practice that specific individuals within our workforce are assigned the responsibility of implementing and maintaining the HIPAA Privacy and Security Rules' requirements. Furthermore, it is the policy of this Physician Practice that these individuals will be provided sufficient resources and authority to fulfill their responsibilities. At a minimum it is the policy of this Physician Practice that there will be one individual or job description designated as the Privacy Official.

Deceased Individuals: It is the policy of this Physician Practice that privacy protections extend to information concerning deceased individuals.

Minimum Necessary Use and Disclosure of Protected Health Information: It is the policy of this Physician Practice that for all routine and recurring uses and disclosures of protected health information (PHI) (except for uses or disclosures made 1) for treatment purposes, 2) to or as

authorized by the patient or 3) as required by law for HIPAA compliance) such uses and disclosures of PHI must be limited to the minimum amount of information needed to accomplish the purpose of the use or disclosure. It is also the policy of this Physician Practice that non-routine uses and disclosures will be handled pursuant to established criteria. It is also the policy of this organization that all requests for PHI (except as specified above) must be limited to the minimum amount of information needed to accomplish the purpose of the request, and where practicable, to the limited data set.

Marketing Activities: It is the policy of this Physician Practice that any uses or disclosures of protected health information for marketing activities will be done only after a valid authorization is in effect except as permitted by law. It is the policy of this organization to consider any communication intended to induce the purchase or use of a product or service where an arrangement exists with a third party for such inducement in exchange for direct or indirect remuneration, or where this organization encourages purchase or use of a product or service directly to patients to constitute "marketing". This organization does not consider the communication of alternate forms of treatment, or the use of products and services in treatment, or a face-to-face communication made by us to the patient, or a promotional gift of nominal value given to the patient to be marketing, unless direct or indirect remuneration is received from a third party. Similarly, this organization does not consider communication to our patients who are health plan enrollees in conjunction with our provision, coordination, or management of their health care and related services, including our coordination or management of their health care with a third party, our consultation with other health care providers relating to their care, or if we refer them for health care to be marketing, but only to the extent these communications describe: 1) a provider's participation in the health plan's network, 2) the extent of their covered benefits, or 3) concerning the availability of more cost-effective pharmaceuticals. This organization may make remunerated communications tailored to individual patients with chronic and seriously debilitating or life-threatening conditions provided we are making the communication in conjunction with our provision, coordination, or management of their health care and related services, including our coordination or management of their health care with a third party, our consultation with other health care providers relating to their care, or if we refer them for health care. If we makes these types of communications to patients who have a chronic and seriously debilitating or life-threatening condition, we will disclose in at least 14-point type the fact that the communication is remunerated, the name of the party remunerating us, and the fact the patient may opt out of future remunerated communications by calling a toll-free number. This organization will stop any further remunerated communications within 30 days of receiving an opt-out request.

Mental Health Records: It is the policy of this Physician Practice to require an authorization for any use or disclosure of psychotherapy notes, as defined in the HIPAA regulations, except for treatment, payment or health care operations as follows:

A. Use by originator for treatment;

B. Use for training physicians or other mental health professionals as authorized by the regulations; C. Use or disclosure in defense of a legal action brought by the individual whose records are at issue; and

D. Use or disclosures as required by law, or as authorized by law to enable health oversight agencies to oversee the originator of the psychotherapy notes.

Complaints: It is the policy of this Physician Practice that all complaints relating to the protection of health information be investigated and resolved in a timely fashion. Furthermore, it is the policy of this Physician Practice that all complaints will be addressed to Melissa Woods, Practice Manager or David Huezo, who is duly authorized to investigate complaints and implement resolutions if the complaint stems from a valid area of non-compliance with the HIPAA Privacy or Security Rule.

Prohibited Activities-No Retaliation or Intimidation: It is the policy of this Physician Practice that no employee or contractor may engage in any intimidating or retaliatory acts against persons who file complaints or otherwise exercise their rights under HIPAA regulations. It is also the policy of this organization that no employee or contractor may condition treatment, payment, enrollment or eligibility for benefits on the provision of an authorization to disclose protected health information except as expressly authorized under the regulations.

Responsibility: It is the policy of this Physician Practice that the responsibility for designing and implementing procedures to implement this policy lies with the Privacy Official.

Verification of Identity: It is the policy of this Physician Practice that the identity of all persons who request access to protected health information be verified before such access is granted.

Mitigation: It is the policy of this Physician Practice that the effects of any unauthorized use or disclosure of protected health information be mitigated to the extent possible.

Safeguards: It is the policy of this Physician Practice that appropriate safeguards will be in place to reasonably safeguard protected health information from any intentional or unintentional use or disclosure that is in violation of the HIPAA Privacy Rule. These safeguards will include physical protection of premises and PHI, technical protection of PHI maintained electronically and administrative protection of PHI. These safeguards will extend to the oral communication of PHI. These safeguards will extend to PHI that is removed from this organization.

Business Associates: It is the policy of this Physician Practice that business associates must comply with the HIPAA Privacy and Security Rules to the same extent as this Physician Practice, and that they be contractually bound to protect health information to the same degree as set forth in this policy pursuant to a written business associate agreement. It is also the policy of this organization that business associates who violate their agreement will be dealt with first by an attempt to correct the problem, and if that fails by termination of the agreement and discontinuation of services by the business associate, or if that is not feasible, by notification of the HHS Secretary. Finally, it is the policy of this organization that organizations that transmit PHI to this Physician Practice or any of its business associates and require access on a routine basis to such PHI, including a Health Information Exchange Organization, a Regional Health Information Organization, or an E-prescribing Gateway, and Personal Health Record vendors, shall be business associates of this Physician Practice.

Training and Awareness: It is the policy of this Physician Practice that all members of our workforce have been trained by the compliance date on the policies and procedures governing protected health information and how this Physician Practice complies with the HIPAA Privacy

and Security Rules. It is also the policy of this Physician Practice that new members of our workforce receive training on these matters within a reasonable time (you may elect to enter the exact time frame) after they have joined the workforce. It is the policy of this Physician Practice to provide training should any policy or procedure related to the HIPAA Privacy and Security Rule materially change. This training will be provided within a reasonable time (you may elect to enter the exact time frame) after the policy or procedure materially changes. Furthermore, it is the policy of this Physician Practice that training will be documented indicating participants, date and subject matter.

Material Change: It is the policy of this Physician Practice that the term "material change" for the purposes of these policies is any change in our HIPAA compliance activities.

Sanctions: It is the policy of this Physician Practice that sanctions will be in effect for any member of the workforce who intentionally or unintentionally violates any of these policies or any procedures related to the fulfillment of these policies. Such sanctions will be recorded in the individual's personnel file.

Retention of Records: It is the policy of this Physician Practice that the HIPAA Privacy and Security Rules' records retention requirement of six years will be strictly adhered to. All records designated by HIPAA in this retention requirement will be maintained in a manner that allows for access within a reasonable period of time. The records retention time requirement may be extended at this organization's discretion to meet with other governmental regulations or those requirements imposed by our professional liability carrier. It is the policy of this Physician Practice to remain current in our compliance program with HIPAA regulations.

Cooperation with Privacy Oversight Authorities: It is the policy of this Physician Practice that oversight agencies such as the Office for Civil Rights of the Department of Health and Human Services be given full support and cooperation in their efforts to ensure the protection of health information within this organization. It is also the policy of this organization that all personnel must cooperate fully with all privacy and security compliance reviews and investigations.

Investigation and Enforcement: It is the policy of this Physician Practice that in addition to cooperation with Privacy Oversight Authorities, this Physician Practice will follow procedures to ensure that investigations are supported internally and that members of our workforce will not be retaliated against for cooperation with any authority. It is our policy to attempt to resolve all investigations and avoid any penalty phase if at all possible.

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