Notice of Privacy

To our patients: This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the **Health Insurance Portability and Accountability Act of 1996 (HIPAA).**

Our Commitment to your privacy

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

We realize that these laws are complicated, but we must provide you with the following important information:

Use and disclosure of your health information in certain special Circumstances

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.

2. Lawsuits and similar proceedings in response to a court administrative order.
3. If required to do so by law enforcement official.

4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.

5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

6. To federal officials for intelligence and national security activities authorized by law.

7. To Correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.

8. For Workers Compensation and similar programs.

Your rights regarding your health information:

1. **Communications:** You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable request.

2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by your agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.

You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to **Taz Elizabeth Varkey, M.D. at 6310 San Vicente Blvd. Suite #290, Los Angeles, Ca 90048 Tel. (323) 933-2930 Fax. (323) 933-2948.**

4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice to request amendment, your request must be made in writing and submitted to **Taz Elizabeth Varkey, M.D. 6310 San Vicente Blvd. Suite #290 Los Angeles, Ca 90048 Tel: (323) 933-2930 Fax: (323) 933-2948**. You must provide us with a reason that supports your request for Amendment.

5. Right to file a complaint: If you believe your rights have been violated, you may file a complaint with our practice or the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact **Taz Elizabeth Varkey, M.D. 6310 San Vicente Blvd. Suite #290 Los Angeles, Ca 90048 Tel: (323) 933-2930 Fax: (323) 933-2948**. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

6. Right to provide an authorization for other uses and disclosures: Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies, please contact **Taz Elizabeth Varkey, M.D. 6310 San Vicente Blvd. Suite #290 Los Angeles, Ca 90048 Tel: (323) 933-2930 Fax: (323) 933-2948.**

Taz E. Varkey, M.D.
Obstetrics and Gynecology
6310 San Vicente Blvd Suite # 290
Los Angeles, Ca 90048
Phone: (323) 933-2930 Fax: (323) 933-2948

I hereby acknowledge that I have been given a copy of Taz Elizabeth Varkey, M.D. Notice of Privacy Practices.

Signature:_____ **Date.**_____

Name of Patient: _____

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Patient Partnership Plan

Dear Patient,

Welcome to my practice. We intend to provide you with the care and service that you expect and deserve. Achieving your **best possible health** requires a "partnership" between you and your doctor. As our "partner in health," I ask you to help us in the following ways.

Schedule Visits with Dr. Varkey for Routine Well Woman Exams and other Recommended Health Screenings
I understand that Dr. Varkey will explain to me which regular health screenings are appropriate for my age, gender, personal and family history. I understand I will need to complete these recommended health screenings (mammogram, immunizations, pap smears etc.). **These health screenings are tests that can help detect life-threatening diseases and conditions.** If I visit Dr. Varkey only for the treatment of the immediate problems and forget to arrange for regular health screenings, I put myself at risk of letting serious health problems go undetected. I will schedule regular visits with Dr. Varkey to complete my physical exam and to discuss these health screenings.

Keep Follow-up Appointments and Reschedule Missed Appointments
I understand that Dr. Varkey will want to know how my condition progresses after I leave her office. Returning to Dr. Varkey on time gives her the chance to check my condition and my response to treatment. During a follow-up appointment, Dr. Varkey might order tests, refer me to a specialist, prescribe medication, or even discover and treat a serious health condition. If I miss an appointment and don't reschedule, I run the risk that Dr. Varkey will not be able to detect and treat a serious health condition. I will make every effort to reschedule missed appointments as soon as possible.

Call the Office When I Do Not Hear the Results of Labs and Other Tests
I understand that Dr. Varkeys's goal is to report my lab and test results to me as soon as possible. However, if I do not hear from Dr. Varkey's office within the seven days, I will check the patient portal. If I need additional assistance then, I will call the office for my test results.

Inform Dr. Varkey if I decide *Not* to Follow her Recommended Treatment Plan
I understand that after examining me, Dr. Varkey may make certain recommendations based on what she feels is best for my health. This might include prescribing medication, referring me to a specialist, ordering labs and tests, or even asking me to return to her office within a certain period of time. I understand that *not* following my treatment plan can have serious negative effects on my health. I will let Dr. Varkey know whenever I decide *not* to follow her recommendations so that she may inform me of significant risks associated by my decision to delay or refuse treatment.

Thank you for your partnership. As our patient, you have the right to be informed about your health care. We invite you, **at any time**, to ask questions, report symptoms, or discuss any concerns you may have. If you need more information about your health or condition, please ask.

Patient Signature _____ Date _____ Physician Signature _____

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Well Woman Exam Information

A Well Woman Exam is your once-a-year visit for a general check-up. What is included in a Well Woman Exam?

- General physical exam including breast exam
- Pelvic exam and obtaining the Pap Smear, but not the laboratory costs associated with the pap smear
- Update of personal information such as life and work situation
- Review and update of family health history
- Update of current medications, herbs, and supplements
- Evaluation of need for health screening tests (such as mammogram, test for sexually transmitted diseases, and colon cancer screening)
- Review of immunizations, but not the cost of the vaccines

A Well Woman Exam does not include a discussion of new problems or a detailed review of chronic conditions.

Time spent addressing additional concerns during your wellness appointment is not included in the routine preventative annual exam fee, and the additional time spent will be billed to your insurance in addition to the annual wellness visit. This fee will generally be applied to your deductible, and you will likely have some financial responsibility. Additional charges can vary from $75.00 to $120.00 depending upon the time spent and the complexity of the consultation.

What happens if you have a new health concern at the time of your Well Woman Exam?

We will need to decide whether or not to use the appointed time that day to address your problem.
If you choose to keep your scheduled Well Woman Exam appointment, you may defer the health concerns to future scheduled visits. If Dr.Varkey makes time to discuss an additional concern at the time of your Well Woman Exam, you will be charged additional exam fees as per your insurance.

Patient Signature _____ Date _____

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Consent to Use Telemedicine

Patient's Name_____

CONSENT TO USE TELEMEDICINE

I am physically located in California. At the beginning of each telemedicine session, I will help my doctor to complete a check-in to assess the suitability of using telemedicine services by verifying my full name, my current location, my readiness to proceed, and whether I am in a situation conducive to private, uninterrupted communication. By signing this consent, I understand and agree:

1. My doctor is located in and licensed by the State of California. My doctor may not be able to prescribe medications for me and/or may not be able to assist me in an emergency situation when I am located in any other state or country. If I require medication, I may contact my doctor. If I require emergency care, I may call 911 or proceed to the nearest hospital emergency room for help. If I am having suicidal thoughts or making plans to harm myself, I can call the National Suicide Prevention Lifeline at 1-800-273-TALK (8255) for free 24-hour hotline support.

2. I submit to the exclusive jurisdiction of the California state superior courts and agree that any claim, lawsuit, or other legal proceeding arising out of or relating to the telemedicine services provided by my doctor and my doctor's staff will be brought solely and exclusively in California state superior courts. I also agree that the interpretation of this consent will be exclusively governed by and construed in accordance with the laws of California.

3. My doctor believes that telemedicine services are appropriate for my medical condition and that I would benefit from its use despite its risks and limitations. While I

may expect anticipated benefits from the use of telemedicine, no specific results can be guaranteed or assured.

4. If my doctor believes at any time that another form of services (for example, a traditional in-person consultation) would be appropriate, my doctor may discontinue telemedicine services and schedule an in-person consultation with my doctor or refer me to a healthcare provider in my area who can provide such services.

5. I have the right to withdraw consent to the use of telemedicine services at any time and receive in-person healthcare services with my doctor.

6. I received an explanation of how the electronic communications technology will be used for the telemedicine services. I am comfortable with using electronic communications technology to communicate with my doctor and understand there are limitations to the technology which may require an in-person consultation.

7. I agree to have the necessary computer, equipment and internet access for my telemedicine communications. I also agree to arrange for a location with sufficient lighting and privacy and is free from distractions and intrusions during my telemedicine communications.

8. The laws that protect privacy and the confidentiality of my medical information also apply to telemedicine. The medical information that is transmitted electronically by my doctor to me will be encrypted during transmission and will be stored only by my doctor or a service provider selected by my doctor. I understand the dissemination of any personally-identifiable images or information from the telemedicine communication to researchers or other healthcare providers will not occur except as required by federal or California state law.

9. I understand my risks of a privacy violation increase substantially when I enter information on a public access computer, use a computer that is on a shared network, allow a computer to "autoremember" usernames and passwords, or use my work computer for personal communications. I also understand it is my responsibility to encrypt medical information I transmit electronically to my doctor and my failure to use technical safeguards, such as encryption, increases my risks of a privacy violation.

10. No part of the encounter will be recorded without my written consent. Likewise, Dr. Varkey does not give consent for the patient to record the video visit without her written consent.

11. I have the right to access my medical information and obtain copies of my medical records in accordance with California law.

12. I understand that the telemedicine services provided to me will be billed to my health insurance company and that I will be billed for any patient responsibility as per my insurance.

I read and understand the information provided in this Consent to Use of Telemedicine. I discussed any questions I had with my doctor and all of my questions were answered to my satisfaction.

_____ _____

Patient's Signature Date

Taz E. Varkey, M.D.
Obstetrics and Gynecology
6310 San Vicente Blvd Suite # 290
Los Angeles, Ca 90048
Phone: (323) 933-2930 Fax: (323) 933-2948

About Telemedicine

WHAT IS TELEMEDICINE?

Telemedicine (also sometimes called telehealth) services are a way to deliver healthcare services locally to a patient when the healthcare provider is located at a distant site. Telemedicine is generally defined as the use of electronic information and communications technology to exchange medical information from one site to another site to provide medical or surgical treatment to a patient and/or to participate in the medical diagnosis of, or medical opinion or medical advice to, a patient.

When a healthcare provider believes a patient may benefit from the use of telemedicine services, telemedicine can maintain a continuity of care with the provider and facilitate patient selfmanagement and caregiver support of the patient. Telemedicine services often provides a broader access to medical care, eliminates transportation concerns, and increases comfort and familiarity for patients and their families when located in their own homes or other local environments.

However, telemedicine uses new communications technology for which there is little research supporting its effectiveness. For example, telemedicine services may not be as complete as inperson healthcare services because the healthcare provider will not always be able to observe subtle non-verbal communications such as a patient's posture, facial expression, gestures, and tone of voice.

Telemedicine may transfer medical information through the use of interactive, real-time audio/visual technology (for example, video conferencing) or electronic data interchange (for example, computer-to-computer exchanges), or it may transfer medical information through the use of store-and-forward technology (for example, emails). While precautions are taken to secure the confidentiality of telemedicine services, the electronic transmission of medical information can be incomplete, lost or otherwise disrupted by technical failures. Additionally, despite such measures, the transmission and storage of medical information can be accessed by unauthorized persons, causing a breach of the patient's privacy.

I read and understand the information provided in this document. I discussed any question I had with my doctor and all of my questions were answered to my satisfaction.

Patient Signature _____ Date _____

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Patient Record of Disclosures

In general, the HIPPA privacy rule gives the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI is made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

Home Telephone: _____

- ☐ *Ok to leave message with detailed information*
- ☐ *Leave message with call back number only*

Work Telephone: _____

- ☐ *Ok to leave message with detailed information*
- ☐ *Leave message with call back number only*

Cellular Telephone: _____

- ☐ *Ok to leave message with detailed information*
- ☐ *Leave message with call back number only*

Email Communications

- ☐ *Ok to email with information about health education opportunities, newsletters or seminars.*

If you would like to give our office permission to discuss your protected health information and your account/billing information with your spouse or any other individual, please list the names of these individuals here:

_____
_____
_____
_____

Patient Portal:

_____ ***Initials*** *I understand that the patient portal is **not** to be used for urgent issues and messages may not be seen for up to 48 hours.*

Patient Signature: _____ ***Date:*** _____

Print Name: _____ ***Date Of Birth:*** _____

Medical Record Number: _____

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Obstetrics, Gynecology and Infertility
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Los Angeles, Ca 90048
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REGISTRATION FORM

Today's date:

Referring Physician:(If applicable)

PATIENT INFORMATION

Patient's last name: First: Middle: ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms.

Marital status (circle one)
Single / Mar / Div / Sep / Wid

E-mail address: PRIMARY CARE PHYSICIAN Name & Phone number: Social Security number: Birth date: / / Age: Sex: ☐ M ☐ F

Street address: Cell phone number: ( ) Home phone number: ( )

P.O. box: City: State: ZIP Code:

Occupation: Employer: Employer phone no.: ( )

How do you prefer to receive your statements (please check one box): ☐ Fax ☐ E-Mail ☐ Mail

Who may we thank for your referral?

INSURANCE INFORMATION

Please give your insurance card to the receptionist.

IN CASE OF EMERGENCY

Name of local relative or friend: Relationship to patient: Home phone no.: ( ) Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Dr. Varkey. I understand that I am responsible to check my insurance benefits for in-network status. If Dr. Varkey's office has checked my benefits, this doesn't ensure guarantee of payment. I understand that I am financially responsible for all balances that are not paid by my insurance company. I also authorize Taz Elizabeth Varkey, M.D. or my insurance company to release any information required to process my claims.

Patient Signature *Date*