The Unger Primary Care Medical Center

Patient Information

Patient Name:_____ Date of Birth:_____

Address:_____ City:_____ Zip:_____

Home Phone #:_(_____)_____ Cell Phone #:_(_____)_____

Social Security #:_____ Sex:_____ Marital Status:_____

Name of Employer:_____ Phone#:_(_____)_____

Address:_____ City:_____ Zip:_____

Job Title:_____

Email Address:_____

Insurance Information

Name of Insurance:_____

Policy Number:_____

Subscriber Name:_____ Relationship to Patient:_____

Do you have additional insurance? _____YES _____NO

Name of Insurance:_____

Policy Number:_____

Subscriber Name:_____ Relationship to Patient:_____

Emergency Contact Information:

Name:_____ Phone #:_(_____)_____

Relationship:_____

Name:_____ Phone #:_(_____)_____

Relationship:_____

Today's Date:_____ How did you hear about Dr. Unger? _____

UNGER | Primary Care Concierge Medical Center

Welcome to Unger Primary Care and Concierge Medicine

Your first appointment has been scheduled with Dr. Jeff Unger. As usual, your office visit will be filed to your insurance company and you will be responsible for any co-pays.

Dr. Unger is a full time Concierge Physician with Cypress Concierge Medicine. Therefore, if you wish to continue to see Dr. Unger as your Primary Care Physician, following your first appointment, you will need to become a member of his Concierge practice. There is a fee associated with this program that is not part of your personal insurance.

Please feel free to speak with Dr. Unger about the benefits of membership. Additional questions about membership can be handled through Lisa Davis, our Office Manager. You are also welcome to visit his webpage at www.yourcypress.com/DrUnger.

Some of the benefits of membership may include:

*Direct after hours communication via cell phone and email

*Expedited appointment scheduling, priority scheduling for complete physicals

*Minimal wait time in the waiting room

*Coordination of care with specialists and scheduling of special testing or procedures

*Physician guided wellness plan

*Individualized treatment strategies and focus on preventive care

Patient Name	Patient Signature	Date

The Unger Primary Care Medical Center

Passionate care of patients with chronic illnesses

Jeff Unger, MD

Associate Director of Metabolic Studies, Catalina Research Institute

14726 Ramona Ave
Suite 110
Chino, Ca. 91710

August 29, 2011

Notice to Patients Regarding Research Participation

Dear Patients:

Dr. Unger and Catalina Research Institute (CRI) are separate corporate entities. Although Dr. Unger does primary care, he does assist CRI in recruiting, screening and monitoring patients involved in clinical trials. Clinical trial patients are NOT charged for participation in research studies once they sign informed consent. If a patient is seen by Dr. Unger *within the clinical trial setting* for any issues directly related to the trial for which the patient signed informed consent, no charges will be incurred.

A research patient who requests to be seen by Dr. Unger for a medical problem un-related to the research protocol will be charged for their visit. In addition, anyone who is evaluated as a possible candidate for a study before informed consent is signed may be charged by Unger Primary Care for that visit.

Research or private patients who have questions or concerns about billing practices will be directed to members of Dr. Unger's staff for clarification by CRI.

_____

Patient signature

Date_____

Phone: 909-590-8409
Fax: 909-590-8695

Unger Primary Care Concierge Medical Group
9220 Haven Ave suite 230
Rancho Cucamonga CA 91730
909-484-2105 phone 909-484-2104 fax

Appointment Cancellation Policy

If you have a scheduled appointment and cannot make it, you **MUST** notify the office **24 hours before** your appointment. If you fail to call or come in, you will be charged $25.00, as this time could have been used for another patient.

If you have any questions regarding this policy, please do not hesitate to ask any one of our staff members.

I have read, understand and agree to the above appointment cancellation policy.

Patient Signature:_____ Date:_____

Witness:_____

Effective September 2009

Model HIPAA Notice of Privacy Practices
Unger Primary Care

Effective Date: Aug. 28, 2013

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.

OUR OBLIGATIONS:

We are required by law to:

- Maintain the privacy of protected health information
- Give you this notice of our legal duties and privacy practices regarding health information about you
- Follow the terms of our notice that is currently in effect

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION:

The following describes the ways we may use and disclose health information that identifies you ("Health Information"). Except for the purposes described below, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our practice Privacy Officer.

For Treatment. We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

For Payment. We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company or a third party for the treatment and services you received. For example, we may give your health plan information about you so that they will pay for your treatment.

For Health Care Operations. We may use and disclose Health Information for health care operations purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the obstetrical or gynecological care you receive is of the highest quality. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services. We may use and disclose Health Information to contact you to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research. Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

SPECIAL SITUATIONS:

As Required by Law. We will disclose Health Information when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Organ and Tissue Donation. If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement, banking or transportation of organs, eyes or tissues to facilitate organ, eye or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation. We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities. We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Data Breach Notification Purposes. We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release Health Information if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We also may release Health Information to funeral directors as necessary for their duties.

National Security and Intelligence Activities. We may release Health Information to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.

Protective Services for the President and Others. We may disclose Health Information to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or to conduct special investigations.

Inmates or Individuals in Custody. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be if necessary: (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

USES AND DISCLOSURES THAT REQUIRE US TO GIVE YOU AN OPPORTUNITY TO OBJECT AND OPT

Individuals Involved in Your Care or Payment for Your Care. Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your Protected Health Information that directly relates to that person's involvement in your health care., If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

Disaster Relief. We may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practically can do so.

YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES

The following uses and disclosures of your Protected Health Information will be made only with your written authorization:

1. Uses and disclosures of Protected Health Information for marketing purposes; and

2. Disclosures that constitute a sale of your Protected Health Information

Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose Protected Health Information under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

YOUR RIGHTS:

You have the following rights regarding Health Information we have about you:

Right to Inspect and Copy. You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing, to Unger Primary Care. We have up to 30 days to make your Protected Health Information available to you and we **will** charge you a reasonable fee for the costs of copying, faxing, mailing or other supplies associated with your request. Our standard fees for these services range from $25-50 per chart. Additional fees may apply if your medical file is more extensive. You may also be charged a fee if you need the information for a claim for benefits under the Social Security Act or any other state of federal needs-based benefit program.

Right to an Electronic Copy of Electronic Medical Records. If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your Protected Health Information in the form or format you request, if it is readily producible in such form or format. If the Protected Health Information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

Right to Get Notice of a Breach. You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

Right to Amend. If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to Unger Primary Care. The amended statement will be dated and noted in the medical file.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to Unger Primary Care.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to Unger Primary Care. We are not required to agree to

your request unless you are asking us to restrict the use and disclosure of your Protected Health Information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us "out-of-pocket" in full. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Out-of-Pocket-Payments. If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by email or at work. To request confidential communications, you must make your request, in writing, toUnger Primary Care. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our web site, www.jeffungermd.com. To obtain a paper copy of this notice, please request one from the front desk supervisor.

CHANGES TO THIS NOTICE:

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.

COMPLAINTS:

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact Lisa Davis: mdsdoll2@aol.com . All complaints must be made in writing. **You will not be penalized for filing a complaint.**

_____

Name

_____

Date

Patient Name

Release and Assignment: I hereby authorize The Unger Primary Care Medical Center to release to my insurance company or its representatives, any information, including diagnosis and the records of any treatment or examination rendered to me during the period of such medical or surgical care.

I also authorize and request my insurance company to pay directly to The Unger Primary Care Medical Center or its physicians the amount due me in my pending claim for medical or surgical treatment of services. In such cases, if I should be paid by the insurance I agree that I am responsible for the payment to The Unger Primary Care Medical Center. I also acknowledge my responsibility for payment of any monies not covered by my insurance.

Signature of Patient (or parent of minor) **Date**

Medical Beneficiary Claim Authorization

I request that payment of authorized Medicare benefits be made either to me or on my behalf to The Unger Primary Care Medical Center for any services furnished to me by their physicians/suppliers. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable to related services.

I understand my signature requests payment be made and authorize release of medical information necessary to pay the claim. If Item 9 of the HCFA-1500 claim form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charges determined of the Medicare carrier as full charge, and the patient is only responsible for the deductible, co-insurance and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

Beneficiary Signature **Date**

Financial Policy

Unger Primary Care Medical Center

We are committed to providing each patient with quality, cost-effective health care. We ask that all patients carefully read our Financial Policy and sign an acknowledgement of receipt, prior to seeing a medical care provider. If you have any questions or concerns about our payment policies please do not hesitate to ask our business office personnel.

As a courtesy we will bill your insurance company. Dr. Unger is only contracted (in-network) with some insurance companies. In the case that we are not contracted with your insurance company, you willbe responsible for any out-of-network charge^ not paid by your insurance company.

Please understand the following:

1. Your insurance policy is a contract between you, your employer, and the insurance company. We are NOT a party to that contract. Our relationship is with you, not your insurance carrier.
2. Aii charges are your responsibility whether your insurance company pays or not.
3. Fees for services, along with unpaid deductibles and co-payments, are due at the time of treatment.
4. We accept cash, check, or credit cards.
5. If the insurance company does not pay your balance in full within 30 days we ask that you contact the carrier to request prompt payment. Ptease inform our office of the carrier's response.
6. Unpaid balances over 90 days may be subject to collections via small claims court, attorney, and/or collection agency with applicable collection fees, All collection fees are the responsibilty of the patient.

We understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate any such problems so that we can assist you in the management of your account.

The following fees are not billed to insurance companies and are the responsibility of the patient.

Medical Records (faxed or printed copies)	$25.00 minimum charge
Co-pay not paid at the time of service	$10.00
Returned checks	$25.00
Paperwork completed by Medical Staff (ie. Disability forms)	$50.00 and up
Missed appointment with less than 24 hour notice	$25.00
Missed new patient appointment	$50.00
MFLA Forms	Pt must complete the entire form which Dr. will sign
Letters on behalf of patient	$75 per page
Completion of any long-term disability forms	$100-150
School health questionnaires	$25