Privacy Acknowledgment and General Consent

<table>
<tr><td colspan="2">I understand that my privacy is protected and I have received a copy of the Notice of Privacy Practices.</td><td colspan="2">☐ Yes</td></tr>
<tr><td colspan="2">I have been offered Advance Directive information. (Not applicable to patients under 18 years old.)</td><td colspan="2">☐ Yes</td></tr>
<tr><td colspan="2">I consent to treatment and authorize health care services to be provided by Prima Medical Group which may include, but is not limited to, one or more of the following: routine diagnostic procedures, radiology, laboratory, minor in-office procedures and medication administration.</td><td colspan="2">☐ Yes</td></tr>
<tr><td colspan="2">I have read and I understand the office and financial policies. I understand that any violation of these terms is subject to referral to a collections agency and/or immediate dismissal from the practice.</td><td colspan="2">☐ Yes</td></tr>
<tr><td colspan="2">I give my physician and/or my physician's representative permission to leave a confidential message for me at the following phone number:</td><td colspan="2">Ph:</td></tr>
<tr><td>I give my physician and/or my physician's representative permission to discuss my medical care with:</td><td colspan="2">Name/Relationship:</td><td>Ph:</td></tr>
<tr><td colspan="2">Prima Medical Foundation participates in the California Immunization Registry (CAIR). I understand that my, or my child's information will be included in that registry unless I choose not to participate.</td><td colspan="2">Please select one of the following options:
☐ I choose to participate in CAIR.
☐ I choose to decline participation in CAIR.</td></tr>
</table>

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

______________________________ ____

Today's Date **Patient Name (Print)**

______________________________ ____

Patient Date of Birth **Signature of Patient/Parent/Guardian**

____

If patient is a minor, relationship to patient

For office use only

I attempted to obtain the patient's signature in acknowledgment of this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date: __________ Signature: ____

Reason: ____

9 Commercial Blvd. Suite 200 Novato, CA 94949

Privacy Acknowledgment and General Consent Effective: July/2012 Revised as of December/2015