3160 Garrity Way
San Pablo, CA 94806

Integrated Pain Care
A Pain Management Clinic of Excellence

Tel (510) 758-7462
Fax (510) 758-7454

# AUTHORIZATION FOR RELEASE OF RECORDS

RE: _____ AKA:_____

DATE OF BIRTH:___/____/____ SS#:_____-_____-_____

**TO:**_____

_____

_____

**I hereby authorize and request that you release to:**

***Gary Martinovsky, MD***
3065 Richmond Pkwy, Ste 101
Richmond, CA 94806

**The complete medical records in your possession concerning my illness and/or treatment during the period from _____/_____/_____ to <u>Present,</u>**

**DATE: _____/_____/_____** **Signed:_____**
**Patient or nearest relative**

_____ _____
**Witness** **Relationship**

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# AUTHORIZATION TO TREAT

By signature below and in compliance with Labor Code Section 4600, 4601 & Regulations 9785 & 9785.5, I hereby certify that I have chosen Gary Martinovsky, MD at 3065 Richmond Pkwy, Ste. 101, Richmond, CA 94806 as my Primary Treating Physician.

NAME (please print): _____Date:_____

Signature:_____

Witness:_____

# CONSENTIMIENTO PARA TRATAMIENTO

Por medio de mi firma y en conformidad con el codigo de Trabajo Articulos 4600, 4601 y Reglas 9785 y 9785.5, por el/la presente certifico que he elejido a Gary Martinovsky, MD como mi Doctor Primario para tratamiento a 3065 Richmond Pkwy, Ste. 101, Richmond, CA 94806.

NOMBRE (letra de molde): _____Fecha:_____

Firma:_____

Testigo:_____

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Tax ID #: 270360730

## Gary Martinovsky, M.D.

I hereby acknowledge that I received a copy of this medical practice's notice of privacy practice. I further acknowledge that a copy of the current notice will be posted in the reception are, and that a copy of any amended Notice of Privacy Practice will be available at each appointment.

I would like to receive a copy of any amended Notice of privacy Practice by

E-mail at _____.

Signed:_____ Date:_____

Printed Name:_____ Telephone:_____

If not signed by the patient, please indicate relationship:

( ) Parent or guardian of minor patient

( ) Guardian or conservation of incompetent patient

Name and address of patient:_____

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# CALIFORNIA LABOR CODE SECTION 5401.7

**Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining Workers' Compensation benefits or payments is guilty of a felony.**

I, _____, declare under penalty or perjury that I have read and understand the above notice.

_____ _____

SIGNATURE OF PATIENT DATE

_____ _____

SIGNATURE OF WITNESS DATE

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_____

_____

_____

TO WHOM IT MAY CONCERN:

This is to notify you that your employee Mr./Mrs. _____ has filed a Claim for Workers' Compensation Benefits, and in relation to this claim and in compliance with Labor Code Section 4600, 4601 and Regulations 9785 and 9785.5 has designated Gary Martinovsky, as his/her Primary Treating Facility/physician of choice. We hereby request compliance with regulation 9784 in serving this medical clinic with all reports, x-rays, raw data and personnel records that pertain to his applicant. We further request authorization to provide medical treatment to said applicant in compliance with Labor Code 139.31. We seek your cooperation and assistance to assure that the employee/patient receives proper medical evaluation and care.

Following Labor Code Sections 5401 and 3711, this notice, with the attached copy of the Employee's Claim for Workers' Compensation Benefits (DWC-1 Form) serves as your legal notification of said action.

Pursuant to Labor Code Sections 5401 and 3711, you are required to immediately advise this office of the name and address of your Workers' Compensation Insurance Carrier. You are also obligated to complete the bottom of the enclosed Claim Form and return it within one day. Please forward said copy to the above referenced address as we are acting as the employee's evaluating and/or treating physician with regard to the patient's injury(ies) or illness (es). Please note that pursuant to Labor Code Section 132 (a) it is unlawful to discriminate against an employee for claiming an industrial injury.

The requested information must be provided even though you may feel this claim is unfounded and should be denied.

_____ _____

Administration Patient

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Tax ID #: 270360730

**Gary Martinovsky, M.D.**

## PATIENT NON-DISCLOSURE STATEMENT

I, _____ understand that my physician has the ability to provide me with some of the medications that I may need for my treatment. However; I understand that I will always be given the option to receive a written prescription that I may have filled at the pharmacy of my choice.

Signature: _____ Date:_____

## NO DIVULGACION DE ESTADOS PARA EL PACIENTE

Yo, _____ entiendo que mi medico tiene la habilidad de proveerme con alguna de la medicina necesaria para mi tratamiento. Sin embargo, entiendo que siempre tengo la opcion de recivir una prescripcion escrita y adquirirla en la farmacia de mi preferencia.

Testigo:_____ Fecha: _____

# NOTICE OF PRIVACY PRACTICES

Effective April 14, 2003

**The privacy of your protected health information is important to us. Please review this notice carefully, as it describes how your medical information is used and maintained by our organization and by our offices and work staff. It also describes your rights as to the information and how you can get access to it.**

PLEASE CONTACT OUR PRIVACY OFFICER (contact information below) WITH ANY QUESTIONS THAT YOU MAY HAVE REGARDING THIS NOTICE. WE URGE YOU TO REVIEW THIS NOTICE CAREFULLY AND ASK ANY QUESTIONS THAT YOU MAY HAVE ABOUT THE USE OR SHARING OF YOUR PROTECTED HEALTH INFORMATION.

**Your Protected Health Information**

Whenever you receive or request durable medical equipment or services from our organization through a prescription, we receive and create personal medical information about you, and about the equipment or services you receive or request. We need this information in order to provide equipment or services to you and to comply with certain legal requirements. It is our goal to make sure that the personal medical information we receive or create about you is kept strictly private. It is necessary, however, to use it or share this information with others from time to time, but only under proper circumstances.

This Notice describes how we may properly use and share your medical information, which we will refer to as "protected health information." This Notice also describes your rights to access and control your protected health information. In reviewing this Notice, it may appear that your medical information is used or shared in many ways. But, this is a comprehensive list and certain events may never occur or might happen only once or a few times. For the most part, your medical information is used or shared only in connection with the equipment or services that we provide you.

We have an obligation to make sure that we give you a copy of this Notice and follow its terms. This Notice applies to protected health information generated at each of our offices.

When we refer to "we" or "us" in this Notice, we mean our organization and our staff, and also refer to each of our offices, and the technicians and other work force staff who contribute to your care. We will provide you with a list of the persons and locations covered by this Notice upon your request.

HOW WE USE OR SHARE PROTECTED HEALTH INFORMATION

**Typical Uses and Sharing:**

Your protected health information may be used or disclosed for these typical situations, without your prior authorization

**Treatment**: We will use and disclose your protected health information in order to provide durable medical equipment and services or to assist physicians or other health care providers assess you medical condition or treat you. We may disclose your protected health information to your primary care or family physician, to a Integrated Pain Care physician, to a specialist, or to another clinic, physician, hospital or other health care provider who requests this information in connection with your care and treatment. Your shared protected health information may include information that we receive from Integrated Pain Care or from other physicians or health care providers. For example, we may have receive and maintain an order from your physician and sleep study test results, which we may need in order to determine the durable medical equipment and services that you require. We may in turn disclose information regarding your durable medical equipment and services and other protected health information in our possession to your personal physician or other health care provider who is treating you.

**Payment**: We may use and disclose your protected health information in order to obtain payment for our services or to allow insurance companies, health plans, government agencies and managed care companies to process claims for services rendered by us to you. For example, we may need to give your health plan information about your health condition in order to obtain authorization for you to receive durable medical equipment or services.

**Health Care Operations**: We will use and disclose your protected health information in order to evaluate the quality and appropriateness of care provided by our physicians and health care professionals. We may need to use and disclose protected health information in connection with our licensing, payment certification, and other status. We may use and disclose your protected health information in our organization's day-to-day operations to enable it to operate smoothly, efficiently and in compliance with applicable laws. As examples, your protected health information may be used for routine activities such as calling you to remind you of a scheduled test. We may also consider your information in planning, as well as use your information to assist in training.

**Employer/Plan Sponsors**: We may disclose your protected health information to your employer or other group health plan sponsor in connection with administration of the health plan and/or payment for services. Information to your employer that falls outside of these purposes may require your prior written authorization.

**Healthcare Information**: We may use your protected health information to contact you from time to time with information about services that we offer, to coordinate your care with other health care providers, or with treatment alternatives. If you do not wish to receive this type of information, you may opt out of receiving this information by contacting the Privacy Officer in writing. However, even if you elect not to receive this information, you may still continue to receive information made available to patients generally, such as newsletters or updates.

**You, Family and Close Friends**: We may disclose your protected health information to you, unless there is information in your file that we are not legally authorized to release to you, such as information related to psychotherapy. We may also disclose information to a family member, friend or other person if you are incapacitated such as in a medical emergency or disaster relief. We will disclose this information only to the extent necessary to help with your health care or with payment for your health care.

**Public Health and Safety; Research**: We may use and disclose your protected health information to the extent necessary to avert a serious and imminent threat to your health or safety or the health or safety of others. We may use or disclose your protected health information for limited research purposes.

**Outside Service**: We may also need to share your protected health information with outside individuals or companies that perform services for us. For example, if we use a vendor or contractor to perform such things as billing or practice management, they may need access to your protected health information. We ask that any outside service or vendor safeguard the privacy of your protected health information in their possession. We do not intend to share your information with any outside service that does not need your information to do its job, such as maintenance crews.

**Unintended Disclosure**: We will try our best to prevent this, but it is possible that others may learn of protected health information because they hear or see information that is not meant for them. For example, another patient might overhear a conversation between you and a durable medical equipment or service technician. We use reasonable efforts to try to prevent any such disclosure from occurring.

**Authorized Use or Disclosure**:

If you specifically authorize us to do so in writing, we will share your protected health information to persons who are not involved with your care and not included in one of the categories listed above. This might include, for example, your employer (for reasons other than related to health plan administration), a life insurance company or a distant relative. Our Privacy Officer or our staff will provide the necessary form for this authorization. You may cancel this authorization at any time.

**Unusual Uses or Disclosures.**

Among the unusual uses or disclosures that may occur without your prior authorization are the following:

**Required by Law**: We will use or disclose your protected health information when we are required to do so by law. For example, we would be required to share such information with a government agency in connection with an audit or investigation, or if we are required by law to report a health condition to a federal, state or local agency.

**Process and Proceedings**: We may disclose your protected health information in response to a court or administrative order, subpoena, discovery request or other lawful process.

**Law Enforcement**: We may disclose limited information to a law enforcement official concerning the protected health information of a suspect, fugitive, material witness, crime victim or missing person. We may disclose the protected health information of an inmate or other person in lawful custody to a law enforcement official or correctional institution under certain circumstances.

**Military and National Security**: We may disclose to Military authorities the protected health information of Armed Forces personnel. We may disclose to authorized federal officials protected health information required for lawful intelligence, counterintelligence and other national security activities.

**INDIVIDUAL RIGHTS**

You have rights with respect to your protected health information. If you have any questions about these rights or want to exercise any of these rights, please contact our Privacy Officer (see contact information below), who will assist you. You may have to pay a fee, depending on your request.

**Inspect and Copy Your Records**: Except for certain mental health information, if any, included in your records, you may inspect and receive a copy of part or all of your protected health information. Your request must be in writing, and we will charge a fee to provide a copy. We also will need a reasonable time to provide the copy, as permitted by law.

**Request Restrictions**: You may request restrictions on how your protected health information is used or disclosed. You can request, in writing, that we place additional restrictions on the use or disclosure of your protected health information. We are not required to agree to these additional restrictions, but if we elect to do so, we will abide by our agreement (except in an emergency).

**Receive Confidential Communications**: You can specify how and where we should send protected health information. For example, you may want all such information in writing, rather than left as a voice message. Or you may request that we send all correspondence for you to your work address. We will accommodate reasonable requests.

**Amend Your Record**: If you feel that health information we have about you is incorrect or incomplete, you may ask us to amend or change the information. However, we might not agree to your request. There are various reasons why we may deny your request for an amendment. If you submit a request for amendment, we will provide you with more information about the process. We will notify you in writing regarding our action on your request.

**Log of Unusual Events**: You have the right to request a log of unusual events that resulted in our sharing protected health information. We are required to maintain events on this list for six years, starting April 14, 2003. The log will only list those disclosures that you have not authorized and which were not related to treatment, payment or our operations. This log might include, for example, the sharing of information with the police or with a government agency, which was necessary without your permission.

**Copy of This Notice**: You may receive, upon request, a paper copy of this notice at any time.

**OUR RIGHT TO CHANGE NOTICE**

We reserve the right to change this notice. We may modify or change our privacy practices from time to time, particularly as new laws and regulations become effective. Any changes will be effective for all the protected health information that we maintain, even information in existence before the change. If we materially modify our privacy practices, we will provide you with a new notice advising you of these changes when you next obtain services from us.

**COMPLAINTS**

If you believe that your protected health information was not handled properly, or feel that we have not allowed you to exercise your rights, you may file a complaint with the Privacy Officer (see contact information below). All complaints must be submitted in writing. You can also contact Region IX of the Office of Civil Rights of the Department of Health and Human Services, at **(415) 437-8310 voice, (415) 437-8329 fax**, or at e-mail address **OCRComplaint@hhs.gov**. We respect your rights and will not retaliate against you or stop your care if you feel it necessary to file a complaint.

**PLEASE SIGN THE ATTACHED ACKNOWLEDGEMENT CONFIRMING THAT YOU HAVE RECEIVED A COPY OF THIS NOTICE.**

**Contact Information**
**Privacy Officer:**

**Integrated Pain Care**
**Telephone: (510) 758-7462**

**Address:**
**Privacy Officer**
**3160 Garrity Way**
**San Pablo , CA 94806**

# W.C. PATIENT INITIAL INTERVIEW CONTROL CHECK-OFF SHEET

**PATIENT'S NAME** _____ **DATE:** _____

***CHECK OFF THE APPROPRIATE BOXES***

**1. Are you a union member?** **Yes☐ No☐**

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**2. Did you have a "carved-out doctor"? (Did you pre-select a doctor in writing and advised your employer PRIOR to the injury?)** **Yes☐ No☐**

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**3. Did you have any previous medical treatment for your industrial injury(ies)?** **Yes☐ No☐**

**A. If the answer is "No", you do not need to proceed with further questions.**

**B. If the answer is "Yes", where were you treated?**

1. **Industrial clinic ("Company Clinic"), referred by the employer** **Yes☐ No☐**
2. **Applicant clinic, referred by the attorney** **Yes☐ No☐**
3. **MPN (Medical Provider Network).** **Yes☐ No☐**

***Did your employer provide you with the name of the doctor or a list of doctors (Medical Provider Network) when you reported your injury to him?*** **Yes☐ No☐**

**If you were treated by an MPN Physician:**

- **Did your employer, within 24 hours after you notified him of the injury, arrange an initial medical evaluation with an MPN physician?** **Yes☐ No☐**
- **If the answer is "Yes", was said medical evaluation scheduled within 3 (three) working days of your request?** **Yes☐ No☐**

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**4. Did your injury occur prior to January 2005?** **Yes☐ No☐**

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**5. Did you have chiropractic treatment (adjustments)?** **Yes☐ No☐**

**If the answer is "Yes", how many chiropractic adjustments have you had to the best of your recollection?** _

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**6. Did you have physical therapy treatment?** **Yes☐ No☐**

**If the answer is "Yes", how many physical therapy treatments have you had to the best of your recollection?**

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**7. Did you have acupuncture treatment?** **Yes☐ No☐**

**If the answer is "Yes", how many acupuncture treatments have you had to the best of your recollection?**

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**Thank you for providing this important information.**