GOLDEN GATE SPORTS MEDICINE & ORTHOPAEDIC SURGERY

PATIENT REGISTRATION FORM

Contact Information

Last Name		First Name		Date of Birth
Street Address		City	State	Zip Code
Home Phone	Cell Phone	May leave a confidential voicemail? Y N	E-Mail Address	
Social Security No.		Male ☐ Female ☐	Age	Marital Status
Emergency Contact Full Name		Relation to Patient	Emergency Contact Phone	

Referral Information

Referred By Phone #	Primary Care Physician Phone #

Reason For Visit

Purpose of appointment:	Consultation Only ☐	Consultation and Treatment ☐	Second Opinion ☐
Which part of the body does this concern?	Left Side ☐	Right Side ☐	
Is this an illness or an injury?	How long have you had this injury? (Date of Injury)		
If this is an injury, it happened:	At Work ☐	At Home ☐	During a Sports Activity ☐	As the Result of an Automobile Accident ☐
Please list any doctors you have previously seen for this condition:			
Please list any studies you have previously done for this condition, including x-ray, MRI, CT, EMG, and bone density scans.			

Study	Body Part	Date of Service	Facility/Location
1. 2. 3. 4. 5.			

Insurance Information

* If this is a workers' compensation injury please skip the primary insurance section and fill out the worker's compensation section

Primary Insurance Provider		ID No./Claim #		Group No. /Date of Injury
Phone Number		Effective Date		
Name of Subscriber	Subscriber's SSN		Subscriber's DOB	Relationship To Subscriber
Secondary Insurance Provider (optional)		ID No.		Group No.
Phone Number		Effective Date		
Name of Subscriber	Subscriber's SSN		Subscriber's DOB	Relationship To Subscriber

New Patient Questionnaire

To safeguard your information, please do not e-mail this form to us.

Patient Information

Last Name	First Name	Date of Birth

Height	Weight	Dominant hand?	Right ☐	Left ☐

Injury

Date of injury	How did the injury occur?
Is the injury better, worse, or the same? Please circle one.	

Aggravating factors:	Relieving factors:

Medical History

Please list all other medical problems (i.e. diabetes, high blood pressure)	
Please list all prior surgeries and hospitalizations	
Please list all allergies	
Have you ever had any abnormal reaction to anesthesia? Y N	Do you have any history of blood clots or easy bleeding? Y N

Social History

Employment Status ☐ Full time ☐ Part time ☐ Retired ☐ Unemployed ☐ Student	Occupation

Employer	Employer City	Employer Phone

How frequently do you smoke?					How frequently do you consume alcohol?				
Never	<1x per month	<1x per week	>2x per week	Daily	Never	<1x per month	<1x per week	>2x per week	Daily
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Family History

Please list any illnesses/conditions in your family:

Condition:	Grandparents	Parents	Siblings	Children	Other
1. _____	☐	☐	☐	☐	☐
2. _____	☐	☐	☐	☐	☐
3. _____	☐	☐	☐	☐	☐
4. _____	☐	☐	☐	☐	☐
5. _____	☐	☐	☐	☐	☐

Review of Systems

Are you currently having or have you ever had problems with these systems. Please check all that apply.

Constitutional
__Change in weight
__Change in appetite
__Weakness
__Fever
__Fatigue
__Malaise
__Night sweats

Eyes
__Changes in vision
__Corrective lenses
__Redness
__Irritation
__Double vision
__Tearing
__Pain

Ears, Nose, Throat
__Ringing in the ears
__Change in hearing/smell/taste
__Headache
__Earache
__Nasal discharge
__Nose bleeds
__Swallowing difficulty
__Hoarseness

Cardiovascular
__Chest pain
__Palpitations
__Shortness of Breath
  __When lying flat
  __On exertion
  __When sleeping at night
__Edema
__Fainting
__Hypertensive disorder
__Hypotensive disorder
__High cholesterol

Respiratory
__Wheezing
__Coughing
__Chest congestion
__Mucus production
__Sleep apnea

Gastrointestinal
__Diarrhea
__Bloody stool
__Nausea
__Constipation
__Incontinence
__Pain
__Bloating
__Ulcers

Genitourinary
__Blood in urine
__Painful urination

Musculoskeletal
__Muscle weakness
__Atrophy
__Joint swelling
__Tenderness
__Rigidity or motion changes
__Contractures
__History of osteoarthritis

Integumentary
__Rashes
__Lesions
__Eczema or psoriasis
__Dermatitis
__Dry or scaling skin
__Changes in skin color
__Skin cancer

Neurological
__Seizures
__Numbness
__Weakness
__Balance issues
__Paralysis
__Memory loss
__Tingling
__Concussion

Psychiatric
__Anxiety
__Depression
__Manic depression
__Bipolar disorder
__Schizophrenia
__Panic attacks
__Sudden mood swings
__Insomnia
__Under psychiatric care
__Delusions/hallucinations
__Paranoia

Endocrine
__Increased appetite
__Heat or cold intolerance
__Diabetes
__Hyperthyroidism
__Hypothyroidism
__Hormone issues
__Low blood sugar
__Decreased appetite
__Excessive thirst
__Excessive urination
__Pituitary gland issues

Hematologic/Lymphatic
__Easy bruising
__Easy bleeding
__Swollen glands
__Swollen extremities
__History of blood clots

Allergic/Immunologic
__Hives
__Hay fever
__Environmental allergies
__Food allergies
__Connective tissue disease
__Immune system problems
__Frequent colds/infections
__Rheumatoid arthritis
__Fibromyalgia

The above information is accurate to the best of my knowledge.

_____ _____

Patient Signature *Date*

Medication Reconciliation

Last Name	First Name	Date of Birth

Please list **ANY** and **ALL** medications you are currently taking to the best of your ability with the medication's name, dosage, frequency and route of administration (if other than oral). This includes all prescription medications, over-the-counter medications, herbal supplements, and vitamin/mineral/dietary supplements.

Medication	Dosage	Frequency	Route of Administration (if oral, please leave blank)

*Use back of page if you need more space for medications.

I hereby attest to completing this form to the best of my knowledge and ability.

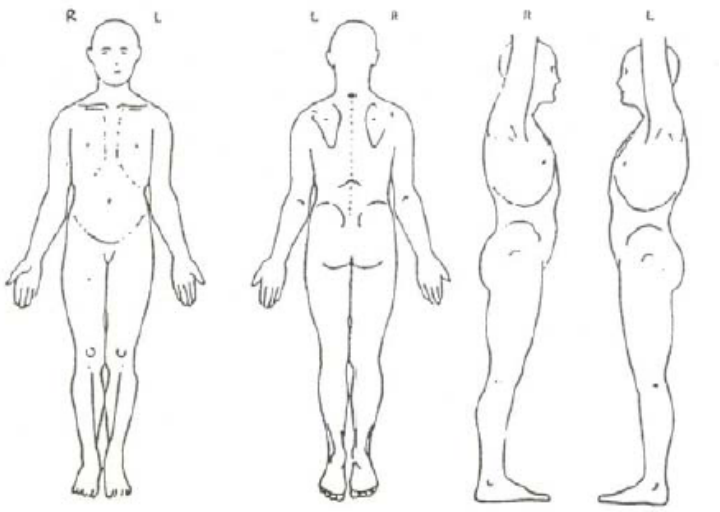
_____ _____

Patient Signature *Date*

Brief Pain Inventory

Last Name	First Name	Date of Birth

1. On the following diagram please mark the area where you feel pain:



For the following questions please circle one number that corresponds to your level of pain (0 – none, 10 – worst possible):

2. **WORST PAIN** during the last week:

0 1 2 3 4 5 6 7 8 9 10

3. **LEAST PAIN** during the last week:

0 1 2 3 4 5 6 7 8 9 10

4. **AVERAGE** pain:

0 1 2 3 4 5 6 7 8 9 10

5. **CURRENT** pain:

0 1 2 3 4 5 6 7 8 9 10

6. How much relief do pain medications or treatment provide? Please circle the corresponding percentage of pain relief:

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

7. How does your pain interfere with the following activities/experiences (0 – none, 10 – completely):

a)	General activity:	0	1	2	3	4	5	6	7	8	9	10
b)	Mood:	0	1	2	3	4	5	6	7	8	9	10
c)	Ability to walk:	0	1	2	3	4	5	6	7	8	9	10
d)	Work:	0	1	2	3	4	5	6	7	8	9	10
e)	Social interactions:	0	1	2	3	4	5	6	7	8	9	10
f)	Sleep:	0	1	2	3	4	5	6	7	8	9	10
g)	Quality of life:	0	1	2	3	4	5	6	7	8	9	10

Office Use Only

Pain Severity Score [Questions (2+3+4+5)/4]:___/10

Pain Interference Score [(Sum of 7a through 7g)/7]: ___/10

NOTICE OF OFFICE POLICIES

GOLDEN GATE SPORTS MEDICINE AND ORTHOPAEDIC SURGERY

ELLY LAROQUE, M.D., Q.M.E.
NICHOLAS COLYVAS, M.D.
JOTHI MURALI, M.D.
HILLARY REDLIN, M.D.
ROBERT PURCHASE, M.D.
KRISTIN WINGFIELD, M.D.

ACKNOWLEDGMENT

I acknowledge that I have reviewed the attached Notice of Office Policies regarding:

- Assignment of benefits
- Financial responsibility/Insurance Coverage and Verification
- Authorization to release medical information for billing purposes
- No show and cancellation within 24 hours: $75.00 fee
- Forms: $15/page
- HIPAA notice and acknowledgement

_____ _____
Signature of Patient or Personal Representative Date

_____
(print name)

_____
If you are signing as the personal representative of the patient, please describe your relationship to the patient:

Notice of Office Policies and Privacy Policies to be attached.

Notice of Office Policies

Golden Gate Sports Medicine and Orthopaedic Surgery

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ROBERT PURCHASE, M.D.
KRISTIN WINGFIELD, M.D.

THIS NOTICE DESCRIBES OFFICE POLICIES AND INFORMATION.

I. ASSIGNMENT OF BENEFITS

I hereby assign to Golden Gate Sports Medicine and Orthopaedic Surgery, Inc., 490 Post Street Suite 900, San Francisco, CA, all of my right, title, and interest in and to any and all health care and/or surgical benefits otherwise payable to me for medical treatment.

II. FINANCIAL RESPONSIBILITY/INSURANCE COVERAGE & VERIFICATION

I acknowledge that I am still responsible for paying Golden Gate Sports Medicine and Orthopaedic Surgery, Inc. to the extent that the relevant insurer, plan or payor does not pay Golden Gate Sports Medicine and Orthopaedic Surgery. I agree that I am responsible for paying Golden Gate Sports Medicine and Orthopaedics Surgery for the full amount of the charges for medical treatment provided by Golden Gate Sports Medicine and Orthopaedic Surgery, Inc.

I agree to immediately remit to Golden Gate Sports Medicine and Orthopaedic Surgery, Inc. any and all payments subject to this assignment that I nonetheless receive directly from the relevant insurer, plan, or payor. I understand that my failure to immediately remit such payments to Golden Gate Sports Medicine and Orthopaedic Surgery, Inc. may cause Golden Gate Sports Medicine and Orthopaedic Surgery, Inc. to incur collection costs and attorney's fees to collect such payments from me, and I agree that I shall be liable for Golden Gate Sports Medicine and Orthopaedic Surgery, Inc.'s collections costs and attorney's fees (plus interest on my outstanding balance at the rate of 10% per annum or the maximum amount allowed by law) if I receive payments subject to this assignment and do not immediately remit the payments to Golden Gate Sports Medicine and Orthopaedic Surgery, Inc.

<u>I understand that it is my responsibility to determine if the doctor is a provider of my insurance. If the doctor is out of network, I agree to pay the out of network costs associated with my plan. I agree that any services rendered, and not covered through my insurance plan, I will be responsible for.</u>

III. AUTHORIZATION TO RELEASE MEDICAL INFORMATION FOR BILLING PURPOSES

I hereby authorize the release of medical information necessary to file a claim with my insurance carrier or other third party payer I agree to the assignment of benefits otherwise payable to me, Golden Gate Sports Medicine and Orthopaedic Surgery, Inc., and my surgeon.

IV. NO SHOW AND CANCELLATION POLICY

I acknowledge that cancellations must be made at least 24 hours in advance. In the event that there is a no show for an appointment or a same day cancellation, I will be charged $75. I understand that this charge will not be covered by my medical insurance, as it is not a medical expense.

V. FORMS

I acknowledge I will be charged $15.00 per page for any forms, such as disability forms. Due to the complexity and volume of this paperwork received in the office, I will allow 7-10 business days for the completion of these forms.

Notice of Privacy Practices

Golden Gate Sports Medicine and Orthopaedic Surgery

ELLY LAROQUE, M.D., Q.M.E.
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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.

I. HOW THIS MEDICAL PRACTICE MAY USE OR DISCLOSE YOUR HEALTH INFORMATION

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices with respect to protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our privacy officer. This medical practice collects health information about you and stores it in a chart and on a computer. This is your medical record. The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

A. **TREATMENT**. We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services that we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured.

B. **PAYMENT**. We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.

C. **OPERATIONS**. We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our "business associates," such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them to protect the confidentiality and security of your medical information. Although federal law does not protect health information which is disclosed to someone other than another healthcare provider, health plan, healthcare clearinghouse, or one of their business associates, California law prohibits all recipients of healthcare information from further disclosing it except as specifically required or permitted by law. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their patient-safety activities, their population- based efforts to improve health or reduce health care costs, protocol development, case management or care coordination activities, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, their activities related to contracts of health insurance or health benefits, or their health care fraud and abuse detection and compliance efforts.

D. **APPOINTMENT REMINDERS**. We may use and disclose medical information to contact and remind you about appointments. You may receive an email reminder from our system, on the email address you have provided.

E. **SIGN-IN SHEET**. We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.

F. **NOTIFICATION AND COMMUNICATION WITH FAMILY**. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or, unless you have instructed us otherwise, in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.

G. **MARKETING**. Provided we do not receive any payment for making these communications, we may contact you to encourage you to purchase or use products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments, therapies, health care providers or settings of care that may be of interest to you. We may similarly describe products or services provided by this practice and tell you which health plans we participate in.

H. **SALE OF HEALTH INFORMATION**. We will not sell your health information without your prior written authorization. The authorization will disclose that we will receive compensation for your health information if you authorize us to sell it, and we will stop any future sales of your information to the extent that you revoke that authorization.

I. **REQUIRED BY LAW**. As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.

J. **PUBLIC HEALTH**. We may, and are sometimes required by law to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.

K. **HEALTH OVERSIGHT ACTIVITIES**. We may, and are sometimes required by law to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by federal and California law.

L. **JUDICIAL AND ADMINISTRATIVE PROCEEDINGS**. We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.

M. **LAW ENFORCEMENT.** We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying of locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.

N. **CORONERS.** We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.

O. **ORGAN OR TISSUE DONATION.** We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.

P. **PUBLIC SAFETY.** We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

Q. **PROOF OF IMMUNICATION.** We will disclose proof of immunization to a school where the law requires the school to have such information prior to admitting a student if you have agree to the disclosure on behalf of yourself or your dependent.

R. **SPECIALIZED GOVERNEMNT FUNCTIONS.** We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.

S. **WORKER'S COMPENSATION.** We may disclose your health information as necessary to comply with worker's compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.

T. **CHANGE OF OWNERSHIP.** In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.

U. **BREACH NOTIFICATION.** In the case of a breach of unsecured protected health information, we will notify you as required by law. If you have provided us with a current email address, we may use email to communicate information related to the breach. In some circumstances our business associate may provide the notification. We may also provide notification by other methods as appropriate.

V. **PSYCHOTHERAPY NOTES.** We will not use or disclose your psychotherapy notes without your prior written authorization except for the following: (1) your treatment, (2) for training our staff, students and other trainees, (3) to defend ourselves if you sue us or bring some other legal proceeding, (4) if the law requires us to disclose the information to you or the Secretary of HHS or for some other reason, (5) in response to health oversight activities concerning your psychotherapist, (6) to avert a serious threat to health or safety, or (7) to the coroner or medical examiner after you die. To the extent you revoke an authorization to use or disclose your psychotherapy notes, we will stop using or disclosing these notes.

W. **RESEARCH.** We may disclose your health information to researchers conducting research with respect to which your written authorization is not required as approved by an Institutional Review Board or privacy board, in compliance with governing law.

X. **FUNDRAISING.** We may use or disclose your demographic information, the dates that you received treatment, the department of service, your treating physician, outcome information and health insurance status in order to contact you for our fundraising activities. If you do not want to receive these materials, notify the Privacy Officer listed at the top of this Notice of Privacy Practices and we will stop any further fundraising communications. Similarly, you should notify the Privacy Office if you decide you want to start receiving these solicitations again.

II. **WHEN THIS MEDICAL PRACTICE MAY NOT USE OR DISCLOSE YOUR HEALTH INFORMATION**

Except as described in this Notice of Privacy Practices, this medical practice will, consistent with its legal obligations, not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

III. **YOUR HEALTH INFORMATION RIGHTS**

A. **RIGHT TO REQUEST SPECIAL PRIVACY PROTECTIONS**. You have the right to request restrictions on certain uses and disclosures of your health information by a written request specifying what information you want to limit, and what limitations on our use or disclosure of that information you wish to have imposed. If you tell us not to disclose information to your commercial health plan concerning health care items or services for which you paid for in full out-of-pocket, we will abide by your request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any other request, and will notify you of our decision.

B. **RIGHT TO REQUEST CONFIDENTIAL COMMUNICATIONS**. You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular email account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.

C. **RIGHT TO INSPECT AND COPY**. You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to, whether you want to inspect it or get a copy of it, and if you want a copy, your preferred form and format. We will provide copies in your requested form and format if it is readily producible, or we will provide you with an alternative format you find acceptable, or if we can't agree and we maintain the record in an electronic format, your choice of a readable electronic or hardcopy format. We will also send a copy to another person you designate in writing. We will charge a reasonable fee which covers our costs for labor, supplies, postage, and if requested and agreed to in advance, the cost of preparing an explanation or summary, as allowed by federal and California law. We may deny your request under limited circumstances. If we deny your request to access your child's records or the records of an incapacitated adult you are representing because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision. If we deny your request to access your psychotherapy notes, you will have the right to have them transferred to another mental health professional.

D. **RIGHT TO AMEND OR SUPPLEMENT**. You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. If we deny your request, you

may submit a written statement of your disagreement with that decision, and we may, in turn, prepare a written rebuttal. You also have the right to request that we add to your record a statement of up to 250 words concerning anything in the record you believe to be incomplete or incorrect. All information related to any request to amend or supplement will be maintained and disclosed in conjunction with any subsequent disclosure of the disputed information.

E. **RIGHT TO AN ACCOUNTING OF DISCLOSURES**. You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 18 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.

F. **RIGHT TO A NOTICE**. You have a right to notice of our legal duties and privacy practices with respect to your health information, including a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by email.

IV. CHANGES TO THIS NOTICE OF PRIVACY PRACTICES

We reserve the right to amend our privacy practices and the terms of this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with this Notice. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and a copy will be available at each appointment.

V. COMPLAINTS

Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer listed at the top of this Notice of Privacy Practices. If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to U.S. Department of Health & Human Services. You will not be penalized in any way if you file a complaint.

IF YOU WOULD LIKE TO HAVE A MORE DETAILED EXPLANATION OF THESE RIGHTS OR IF YOU WOULD LIKE TO EXERCISE ONE OR MORE OF THESE RIGHTS, CONTACT OUR PRIVACY OFFICER LISTED HERE.

Golden Gate Sports Medicine & Orthopaedic Surgery
Attention: Privacy Officer
490 Post Street, Suite 900
San Francisco, CA 94102

The Privacy Officer can also be contacted by telephone at (415) 409-1367.

This notice is effective as of January 1, 2016