

Ann Mai, M.D. – Internal Medicine

4950 Barranca Parkway, Suite 207 Irvine, California 92604

Phone (949) 262-9700 - (949) 262-0700 Fax

www.annmaimd.com

info@annmaimd.com

To Our Potential Patients:

You are likely aware of the many changes that have developed over recent years to the practice of Medicine. Our practice has been forced to absorb increased requirements and demands from the insurance industry. This has led us to make a significant change to our practice model so we may be able to continue to offer the highest quality care possible.

We are inviting you to participate in one of our membership practice models - **Level 1** Primary Care or **Level 2** Primary Care program. These memberships are voluntary and very limited. As always, you do have a choice and we are happy to give you alternative options for practices that do not charge a membership fee. Currently, we are only enrolling membership patients in our practice to maintain the highest quality care.

Since moving to this model, we are able to offer improved access for same-day or next-day urgent appointments, routine visits and non-rushed appointments with the doctor. The large number of patients in a traditional practice is reduced in this model and so now you have Dr. Mai and our staff on a more personalized level!

The **Level 1** option includes (but not inclusive of) all of the clerical fees we have previously assessed for such as medication prior authorizations, various forms, lost/misplaced orders, refills, prescriptions called in without a visit (when reasonable), etc... This program DOES NOT include direct messaging (or texting) with our physician. Please call us as would normally do at any doctor's office to reach the staff.

Our **Level 2** option has all the benefits of the Level 1 PLUS a dedicated mobile phone number directly to the physician in case of an emergency. This allows for more personalized coordination of care (especially as patients age and their adult children want to participate in their care but may be in different locations or time zones), specialty referrals and hospital care. Patients in our **Level 2** program are able to text with our physician freely for medically-related issues but this does not replace an office visit.

We ask that you decide on this offer within 30 (thirty) days. We have a long waiting list of patients who need a well-seasoned physician of this caliber. Dr. Mai has over 30 years of experience in Internal Medicine and is dedicated to her patients. We understand the fee may be difficult for some families and will help you find another practice that will be more suitable for you.

Please feel free to contact us if you have any questions. We look forward to your participation and the privilege of providing you the best healthcare possible.

Sincerely,

Ann Mai, M.D., Staff & Affiliated Providers

Frequently Asked Questions

What is the Annual Membership Fee as of January 1, 2026?

The current fee for **Level 1** Primary Care is **\$1100 for all ages**.

The current fee for **Level 2** Primary Care is **\$3,750 for all ages**.

What does this fee cover?

This fee reimburses our practice for services that are not reimbursed by insurance. The fee keeps the practice small and manageable as patients age and acquire more medical issues (we have been in the same location for over 20 years). The smaller number of patients in fact does generate roughly the same volume of work when we were at 5-7 times the number of patients. We now care for more complex, older patients vs 20 years ago. Also, their children have grown up and joined the practice with the parents. We have a queue of potential enrollees and only take on new patients who are motivated to access the best healthcare.

The fee covers all of the non-reimbursable tasks our office carries out to ensure that nothing is overlooked, but also for time spent on tasks that insurance does not reimburse for such medication prior authorizations (so patients are not stuck with cheap formulary options to save insurance companies money), forms from everything to letters for dental surgery clearance to work or school physicals, "lost orders" that have to be reprinted because some patients misplace their orders or forget them as they rush off to a test appointment. We stop what we are doing face-to-face with patients and service these requests, yet we are not reimbursed for the time and resources we spend on this double work. Most businesses at least can charge by the hour or part of it when they have to work on each task.

What happens if I do not want to join?

We do not offer a trial period. If you choose not to join, your health care will be directed over to a medical provider of your choice. Fortunately, we have lots to choose from in this area.

If I sign up, do I still need medical insurance?

Yes, you still need to carry medical insurance and we will continue to bill your medical insurance with every office encounter. Your normal co-payments, co-insurance and deductible continue to apply. This membership fee IS NOT A SUBSTITUTE FOR INSURANCE and cannot be billed to medical insurance. This fee **DOES NOT APPLY** towards your annual deductible.

How do I obtain a patient application and agreement form?

The application and agreement form is in this packet.

What are my payment options?

There is a one-time **Initiation Fee of \$250** along with full payment of the chosen level's Annual Membership Fee. Renewals are due annually by the expiration date of the contract. Any lapse in membership is subject to a \$250 administrative fee to revive the membership - we do not pause memberships for any reason.

Is the Annual Membership Fee tax-deductible?

Some HSA, MRA or FSA accounts have covered these fees in the past 10 years with our existing patients. Please talk to your tax advisor and/or employer about this. We can provide you a detailed receipt upon request.

What are the main differences between the \$3750 (Level 2) vs \$1100 (Level 1) options?

Our Level 2 patients have more prioritized access to Dr. Mai and a dedicated mobile number to address medical issues. Please refrain from contacting Dr. Mai directly (via text) even if you learn of her personal mobile number - this is reserved for her personal use. **Level 2** patients use a different phone number to text with the doctor. At all levels, Dr. Mai can be reached at (949) 262-9700 - 24 hours a day, 7 days a week - follow the prompts. More details can be discussed with the doctor directly.

MEMBERSHIP APPLICATION AND AGREEMENT

_____ (“Patient”) identified would like to participate in the membership practice (“Practice”) offered by Dr. Ann Mai (“Provider”). Patient and Provider acknowledge and agree to the following terms and conditions in connection with participation in the Practice.

LEVEL 1 MEMBERSHIP LEVEL

- Be a member of Dr. Mai’s Primary Care - Internal Medicine Office in Irvine, CA
- Elimination of all administrative fees
- Ability to make appointments online and communicate with the office via **FollowMyHealth.com**
- Same day, next day appointments and/or Virtual Visits via <https://doxy.me/9492629700> for urgent issues
- Medical service to coordinate Patient's complete health care needs, including prescription refills, specialty care referrals, laboratory and diagnostic imaging needs, and prior authorizations for medications or services, form fees (school physical, employer wellness programs, etc...)
- A focus on wellness through the promotion of preventive medicine and the early detection of disease - a comprehensive health assessment in addition to your annual physical
- Telehealth access if you are unable to visit the office

LEVEL 2 MEMBERSHIP LEVEL

- All of the above benefits as above with prioritized appointments and call backs
- Personal coordination of specialty referrals and hospital care
- Annual comprehensive wellness visit to include nutritional counseling
- Direct communication with the doctor via cell phone and/ or text messaging for medically-related concerns

PATIENT COMMITMENTS

To participate in the Practice, Patient will be required to pay an annual fee (Annual Fee) according to the following:

<u>Annual Membership Fee Schedule</u>	<u>1 year</u>
LEVEL 1	\$1100
or	
LEVEL 2	\$3,750
Initial Set Up Fee (one-time)	\$250

- The Annual Membership Fee is for a 12-month period ("Term")
- The Annual Membership Fee is subject to increase at Provider's sole discretion
- The Annual Membership Fee is due on the effective date of this Agreement and on or before each 365-day anniversary thereafter as a condition for continuing as a Patient of the Practice. Practice will notify Patient of any fee increase thirty (30) days prior to the renewal due date
- The Annual Membership Fee is for services that are not considered covered benefits by insurance plans
- The Annual Membership Fee is non-refundable
- Cancellation requires written notice
- If the Annual Membership Fee is not paid within thirty (30) days of your renewal anniversary, we will assume Patient has chosen to move to a different Primary Care Physician’s practice
- To re-join the Practice after a lapsed period, a new Agreement will be started with an extra fee of \$250 to cover administrative costs; this fee is avoided if the contract renews on-time annually
- The Initial Set Up & Annual Fees are never covered by your medical insurance as it covers non-payable expenses Health Savings, Medical Reimbursement, and/or Flexible Spending Accounts have covered these fees previously

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PATIENT ACKNOWLEDGMENTS:

Patient acknowledges that the Practice is a unique program with certain specific limitations, including but not limited to:

- Practice will bill Patient's insurance for services rendered at regular office visits and/or telehealth encounters
- Patient shall remain financially responsible for all charges incurred, including the deductible, co-insurance and co-payments, without exception
- In the event that Dr. Mai is unavailable, call coverage will be provided by another physician
- This Agreement shall renew at the end of the existing Term with Patient's payment of the Annual Membership Fee by the Term's expiration date
- Upon expiration or termination of this Agreement, Practice will transfer Patient's medical records to any physician requested by Patient with written notice and without charge
- If Patient chooses not to renew this agreement (this includes NOT paying the Annual Membership fee by the due date), Practice will provide emergency medical care for 30 days upon knowledge of the termination

If any provision of this agreement is held to be invalid or unenforceable in whole or in part, such invalidity or unenforceability shall attach only to such provision or part thereof and the remaining part of such provision and all other provisions hereof shall continue in full force and effect.

PATIENT ACCEPTANCE:

Name: _____ Date of Birth: _____

Address: _____

Email: _____ Phone (Cell / Home/ Work) _____

Signature

Date

Select one: **\$1100 for LEVEL 1 Primary Care or \$3750 for LEVEL 2 Primary Care**
(A one-time fee of \$250 is added at time of enrollment)

___ Square Invoice for Visa / MC / AMEX / ACH (debit cards)

___ PayPal (payments@annmaird.com)

___ Zelle (ask us)

___ Check payments: ANN MAI, M.D.

PO BOX 13279

Newport Beach, CA

92658

NOTICE OF ACCEPTANCE (to be completed by doctor):

Dr. Mai acknowledges receipt of this agreement and application to become a Patient of:

LEVEL 1 Primary Care or LEVEL 2 Primary Care

This agreement is effective starting _____ at 12:00 am until _____ at 11:59 pm

Signature of ANN MAI, M.D.

Date

ANN MAI, M.D.

Diplomate, American Board of Internal Medicine
4950 Barranca Parkway, Suite 207 Irvine, California, USA 92604
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PLEASE FILL OUT AND SIGN THE BOTTOM

Name _____ Male Female
Date of Birth _____ Marital Status: Single Married Divorced Widowed
Address _____ City / State / Zip _____
Home / Cell Phone _____ Business Phone _____
Email _____ Driver's License Number _____
Social Security Number _____ Referred by _____
Employer's Name _____
Employer's Address _____

RESPONSIBLE PARTY **Check here if same as ABOVE**

Check here if same as patient information and skip to insurance information

Name _____ Male Female
Address _____
Home Phone _____ Business Phone _____
Cellular Phone _____

PRIMARY INSURANCE INFORMATION **Check here if same as BEFORE**

Name of Insurance Plan _____ HMO POS PPO Other
Insurance ID # _____ Group # _____
Address _____ City / State / Zip _____
Name of Insured _____ Employer _____
Date of Birth of Insured _____ SSN of Insured _____
Relationship to Patient: Self Spouse Child Parent Other (specify) _____

SECONDARY INSURANCE INFORMATION **Check here if same as BEFORE**

Name of Insurance Plan _____ HMO POS PPO Other
Insurance ID # _____ Group # _____
Address _____ City / State / Zip _____
Name of Insured _____ Employer _____
DOB of Insured _____ SSN of Insured _____
Relationship to Patient: Self Spouse Child Parent Other (specify) _____

EMERGENCY CONTACT INFORMATION **Check here if same as BEFORE**

Name _____ Relationship _____
Phone Number _____ Can we tell this person what is wrong with you? Yes No

DISCLOSURE – Please read carefully and sign.

I hereby assign my insurance benefits to be made directly to the doctor and/or his/her associates, for services rendered. I hereby attest that the above insurance information is accurate and that I am an eligible member of the stated plan. I understand that I am responsible for knowing my benefits/coverage. I will be financially responsible for all charges that are NOT covered by my insurance company. I also agree to paying all co-payments, co-insurances and/or elective service fees at the time of service. If there are problems collecting payment, attorney's fees, collection agency costs and any related fees will be added to my bill.

I authorize the release of all information other physicians and insurance carriers upon request for the purpose of payment for medical services and further treatment of care by another physician. I further agree that a photocopy of this agreement shall be as valid as the original.

I hereby acknowledge that I have read, understand and agree to hereby give consent to assess, treat and test.

Signature _____ Date _____
 Patient Parent Child Legal Guardian Durable Power of Attorney Other (specify) _____

HEALTH QUESTIONNAIRE

Name (Dr./Mr./Mrs./Ms./Miss) _____ M F Other
 Email _____ Mobile # _____
 Reason for Visit: PHYSICAL / PAP / WELLNESS / PRE-OP / OTHER _____ Date of Birth: _____
 Current prescriptions and/or supplements: _____

Allergies (to meds): NONE / _____

PAST MEDICAL & SURGICAL HISTORY

Please check if YOU have been diagnosed with the following conditions:

- Measles / Mumps Asthma / COPD High blood pressure Sleep apnea / CPAP Hepatitis / Cirrhosis
- Chickenpox Diabetes / Prediab High Cholesterol Chronic insomnia STDs / STIs
- Birth defects Arthritis / Gout Heart attacks / Stents / CABG Rheumatic fever Herpes 1 / 2
- GERD Strokes / Seizures Irreg heartbeat / A fib / Pacemaker / Defibrillator Tuberculosis
- Thyroid disorder Neuropathy Chronic pain _____ Anxiety / Depression Rheumatic fever
- Wear Glasses / Contacts Glaucoma / Cataracts Wear hearing aids Wear dentures Have dental impants
- Cancer Details: _____
- Injuries / Disability / Broken bones Details: _____
- Car accident(s) & details: _____
- Hospitalization(s) Details: _____
- Anesthesia Local Regional General Other / Unknown Details: _____
- Operations: Tonsils / Appendix / Hysterectomy / Vasectomy / Cosmetic Details: _____
- Other serious conditions & details: _____

FAMILY HISTORY

Please check if any blood relative has ever had:

- Breast cancer _____ Colon cancer _____ Other cancers _____
- Mental illness (anxiety / depression / bipolar / other) _____
- Bleeding tendencies Osteoarthritis / Gout Asthma / COPD / Emphysema Smoker? Y / N
- Diabetes / Prediabetes Dementia / Alzheimer's Seizures / Epilepsy Strokes
- Heart disease - heart attacks / stents / bypass surgery High blood pressure High cholesterol
- Tuberculosis Other _____

RELATIVE	AGE	HEALTH ISSUES	AGE & CAUSE OF DEATH
Father			
Mother			
Sibling(s)			
iii M/F			
iii M/F			
Spouse			
Children			
iii M/F			
iii M/F			

Marital Status: Single Married Separated Divorced Widowed Other _____
Sexually active? Yes No If yes, with males with females both Sex life satisfactory? Yes No
Feel safe at home? Yes No Are you living with your spouse/partner/other? Yes No
Dependents at home? Yes No Children / Grandchildren / Pets / Other _____
Do you drink alcohol? Yes No Details: _____
Do you smoke / vape? Yes No Details: _____
Have you ever smoked / vaped? Yes No Details: _____
Do you use drugs? Yes No Details: _____
Regular exercise? Yes No _____ Healthy Diet? Yes No Do you have an Advance Directive? Yes No
Hobbies or what you like to do to relax: _____
Employment: Full-time Part-time Unemployed / Retired Student Details: _____
Time lost due to health reasons: In the past 6 mos? _____ past yr: _____ past 5 yrs: _____

REVIEW OF SYSTEMS

Please CIRCLE if you have or have had any of the following in the **PAST 2 WEEKS**:

GENERAL: Fever Chills Fatigue Weight loss Weight gain Appetite loss/increase Can't sleep Feeling sad/blue Stressed out
SKIN: Itchy Dry Acne Jaundice Hives Eczema Psoriasis Rashes Boils Abnormal pigmentation
HEAD and NECK: Headaches Ear disease Eye disease/injury Double vision Blurry vision Glaucoma Cataracts Itchy eyes
Poor hearing Dizziness Runny nose Sneezing Nosebleeds Sinus trouble Sore throat Mouth sores Stiff neck Enlarged glands
RESPIRATORY: Frequent colds Spitting up blood Cough Wheezing Difficulty breathing Shortness of breath Painful breathing
Pleurisy Pneumonia History of Tb History of COVID Snoring Daytime sleepiness Wake up unrefreshed from sleep
CVS: Chest pain Shortness of breath at rest / with activity Awakening in night smothering Difficulty walking two blocks
Swelling of hands / feet / ankles High blood pressure High cholesterol Heart murmur Valvular heart disease Palpitations
DIGESTIVE SYSTEM: Food sticks in throat Heartburn/Indigestion Ulcer Nausea Vomiting Vomiting blood Gallbladder ds
Liver trouble Cramping Gas/Bloating Diarrhea Constipation Painful stools Hemorrhoids Bloody stools Black stools
GYNECOLOGICAL: Age periods started: _____ Periods come every ___ days Lasting ___ days Flow is light / med / heavy
Last period _____ Painful periods Irregular periods PMS Last Pap _____ HPV history? Y / N
of pregnancies _____ # of abortions/miscarriages _____ Cesarean section Birth control _____
Peri-menopause / Menopause _____ Hysterectomy _____ Fibroids _____ Took hormones? Y / N
Last mammogram _____ Dense breast tissue? Y / N Vaginal / Bladder prolapse Vaginal / Urethral discharge
GENITOURINARY: Circumcised? Y / N Kidney stones Leaky urine Frequent urination Burning/painful urination Blood in urine
Testicular pain / swelling Enlarged prostate Testosterone replacement therapy Last PSA _____
MUSCULOSKELETAL: Falls Balance/Walking Problems Varicose veins Weakness of muscles or joints Pain or swelling of joints
Upper / Mid / Lower Back pain Scoliosis Pain in buttock/calves while walking, relieved with rest Leg / ankle swelling
ENDOCRINE: Thyroid disease Change in hat/glove size Hair loss Always hot / cold Dry skin Coarse hair Hot flashes
Ideal desired weight _____ Current weight _____ Current height _____
HEMATOLOGIC: Slow healing Easy bruising Anemia Phlebitis Blood Clots Had a blood transfusion Cancer _____
NEUROPSYCHIATRIC: Lightheadedness Fainting spells Numbness Tingling Paralysis Weakness Convulsions / Seizures
Disinterest in usual activities Hopelessness Worthlessness Suicidal Poor concentration Memory Loss Anorexia Bulimia

PREVENTIVE

Most recent vaccination: TDAP / Tetanus _____ Flu _____ COVID _____ Pneumonia _____
Shingles (2 doses) _____ RSV _____ I CHOOSE TO NOT VACCINATE _____
Last blood test _____ Last colonoscopy _____ Bone density _____
Eye exam _____ Hearing test _____ Dentist visit _____
Hep C _____ Elective body MRI _____ Elective Coronary Artery Calcium Scan _____

Patient's signature: _____ Date: _____

Reviewed by: _____ / ANN MAI, M.D Date: _____

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TEST RESULTS NOTIFICATION POLICY AND AGREEMENT

We will notify you of test results that your physician has ordered. We do not release results that other providers have ordered. Please contact the office that ordered your test(s) for those results.

It takes up to **two (2) weeks** for results to process and land in your email inbox. If indicated, we will contact you sooner by text and/or telephone for follow up instructions. Mammogram results are directly released by the Radiology office and will NOT be sent out by our office. If you have a special request, please let us know. HIV results can only be obtained by making a follow up visit with the doctor (a virtual visit is OK). We cannot email or mail HIV test results to you. This complies with California State Law. There are no exceptions.

There are 2 faster ways to obtain results:

1 - Log into the original website of the test center. For example, use the Quest Diagnostics or Lab Corp app / website to view your results. Quest and Lab Corp usually post results as soon as they are ready. You can make an appointment with our physician if you want to discuss your results, after you view them - sometimes this is even BEFORE the physician has had time to review them!.

2 - Log into our patient portal followmyhealth.com to view results as they are available to our office. The "invitation code" is your date of birth as in this format: 01312001.

We will email your test results to the email address we have on file. We no longer mail out printed copies of test results, unless otherwise agreed upon between you and your physician. Please wait up to two (2) weeks from the date of the test performed before you contact our office for results - unless the doctor specifically asked you to follow up sooner.

Our office staff is not permitted to release or interpret any results by telephone. If you would like to discuss the test results after you have viewed our email sent to you - please make an appointment with Dr. Mai. We offer virtual visits for your convenience.

___ I authorize this office to leave messages on my voicemail of the mobile phone number provided to this office at the time of registration.

___ I request that no messages be left on my voicemail. I take full responsibility to make a follow up appointment to obtain my results.

FINANCIAL LIABILITY POLICY AND AGREEMENT

___ I understand that all copayments, coinsurance and deductibles are due at the time of service. We will invoice you via text and/or email. Kindly settle the invoice BEFORE your appointment starts (especially if you have a virtual visit). We do not have a "bill me later policy".

___ I understand that if my insurance carrier does not issue payment within 90 days of the date of service, I will be financially responsible for the entire balance. I may pursue my insurance carrier to render payment and once settled, I will receive a refund for any overpayment.

___ I understand that it is my responsibility to inform this office of any changes in my insurance coverage. This office will not re-bill insurance if I fail to update my coverage. We ask you kindly keep us updated in the event you have any changes with or without an appointment. You can always send updated insurance information to our administrative email inbox: 9492629700@myupdox.com

___ I understand that this office does NOT verify benefits before every appointment (we are too busy taking care of patients). I am responsible to know my benefits and will be responsible for contacting my insurance carrier for details.

___ I understand that I will be financially responsible for all services rendered (communicated to me beforehand by the provider) that are not covered by my insurance.

___ I understand that if I violate any terms of this Financial Liability Agreement, I will be discharged from this practice. I will be financially responsible for any outstanding balance on my account plus any associated collection and/attorney fees.

Patient's signature: _____ Date: _____

Printed Name : _____ Date of Birth: _____

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with California and Federal law concerning the privacy of such information.

Failure to provide all information requested may invalidate this Authorization.

I hereby authorize the use and/or disclosure of my health information as described in 6 and/or 6a below.

1. Patient Name: _____ DOB: _____ SSN: _____

2. **Authorize:**
ANN L. MAI, M.D.
4950 Barranca Parkway, Suite 207
Irvine, California 92604 USA
Phone (949) 262-9700 / (949) 262-0700 Fax

3. **To release protected health information to:**
Physician / Facility _____
Address _____
City / Zip _____
Phone / Fax _____

4. **Authorize:**
Physician / Facility _____
Address _____
City / Zip _____
Phone / Fax _____

5. **To release protected health information to:**
Ann L. Mai, M.D.
4950 Barranca Parkway, Suite 207
Irvine, California 92604 USA
Phone (949) 262-9700 / (949) 262-0700 Fax

6. **HEALTH INFORMATION TO BE RELEASED FOR THE FOLLOWING DATES: (Invalid if dates/period not filled in)**

From _____ to _____.
 OB/Gyn Records Lab Reports Billing Records – Specify
 Specific Visits X-Ray Reports Other (please specify) _____

6a. In compliance with California Statutes which require special permission to release otherwise privileged information, please release records pertaining to: (separate specific authorization required)

Mental Health Drug Abuse Alcohol Abuse HIV Tests

7. **PURPOSE OR NEED FOR DISCLOSURE: (Check all that apply – you must choose at least ONE)**

Further Medical Care Disability Determination Workers' Compensation
 At the Request of the Patient Life Insurance Determination Research Drug Study
 Employment Determination Legal Investigation Other

8. **EXPIRATION DATE:**

This Authorization will expire on ___/___/____. If I do not indicate a date, this authorization will expire one (1) year from the date of my signature on this document.

9. SIGNATURE: _____ Date: _____

If signed by someone other than the patient, state your legal relationship to the patient: _____

Witness: _____

If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may be disclosed and may no longer be protected. California law prohibits recipients of your health information from redisclosing such information except with your written authorization or as specifically required or permitted by law.

ADDITIONAL INFORMATION REGARDING RELEASE OF HEALTH INFORMATION

This office recognizes the patient's right of confidentiality of their health information under federal privacy regulations and California law. The patient should be aware of the following information when requesting or releasing health information:

Right to Refuse to Sign this Authorization: This authorization is voluntary. Refusal to sign **will not** affect the patient's ability to receive treatment or payment of claims.

Right to Inspect or Receive a Copy of Health Information to Be Used or Disclosed: A patient has a right to inspect or obtain a copy of the health information they have authorized to be used or disclosed by signing this Authorization form.

Right to Receive a Copy of this Authorization: A patient has the right to receive a copy of the signed Authorization form.

Right to Revoke this Authorization: A patient has the right to revoke this Authorization at any time by giving written notice of revocation to the Privacy Officer. Revocation of this Authorization will not affect any action taken in reliance of this Authorization before receipt of the written notice of revocation.

Multiple Releases of Information: A patient may request multiple releases of the information stated on the Authorization form.

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Acknowledgement of Receipt of Notice of Privacy Practices

Privacy Officer: Michelle Eibl (949) 262-9700 Effective Date: April 14, 2003

Patient's Name : _____ Date of Birth: _____

___ I hereby acknowledge that I received a copy of the Notice of Privacy Practices for the above physician.

___ I further acknowledge that a copy of the current notice is posted in the reception area and that any amended Notice of Privacy Practices will be made available at my next appointment.

Patient's signature: _____ Date: _____
(or representative)

If not signed by the patient, please indicate relationship:

___ parent or guardian of a minor patient

___ guardian or conservator of an incompetent patient

___ beneficiary or personal representative of deceased patient

Notice of Privacy Practices Acknowledgement Tracking Information

Complete the following only if the patient *refuses* to sign the Acknowledgement:

Efforts to Obtain: _____ Date: _____

Reasons for Refusal: _____ Date: _____

Employee Name: _____ Date: _____

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NOTICE OF PRIVACY PRACTICES

Effective Date: April 14, 2003

(updated 4/1/2026)

**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**

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.

A. How This Medical Practice May Use or Disclose Your Health Information

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:

1. **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 which 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.
2. **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.
3. **Health Care 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

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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. We may also share medical information about you with the other health care providers, health care clearinghouses and health plans that participate with us in "organized health care arrangements" (OHCAs) for any of the OHCAs' health care operations. OHCAs include hospitals, physician organizations, health plans, and other entities which collectively provide health care services. A listing of the OHCAs we participate in is available from the Privacy Official.

4. Appointment Reminders. We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.

5. 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.

6. 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.

7. 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. We may receive financial compensation to talk with you face-to-face, to provide you with small promotional gifts, or to cover our cost of reminding you to take and refill your medication or otherwise communicate about a drug or biologic that is currently prescribed for you, but only if you either: (1) have a chronic and seriously debilitating or life-threatening condition and the communication is made to educate or advise you about treatment options and otherwise maintain adherence to a prescribed course of treatment, or (2) you are a current health plan enrollee and the communication is limited to the availability of more cost-effective pharmaceuticals. If we make these communications while you have a chronic and seriously debilitating or life threatening condition, we will provide notice of the following in at least 14-point type: (1) the fact and source of the remuneration; and (2) your right to opt-out of future remunerated communications by calling the communicator's toll-free number. We will not otherwise use or disclose your medical information for marketing purposes or accept any payment for other marketing communications without your prior written authorization. The authorization will disclose whether we receive any financial compensation for any marketing activity you authorize, and we will stop any future marketing activity to the extent you revoke that authorization.

8. 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.

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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.

10. 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.

11. 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.

12. 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.

13. 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 or locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.

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

15. Organ or Tissue Donation. We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.

16. 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.

17. Proof of Immunization. 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 agreed to the disclosure on behalf of yourself or your dependent.

18. Specialized Government 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.

19. 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.

20. 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.

21. 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.

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your written authorization is not required as approved by an Institutional Review Board or privacy board, in compliance with governing law.

23. 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.

B. 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.

C. Your Health Information Rights

1. 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.

2. 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.

3. 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.

4. 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

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to any request to amend or supplement will be maintained and disclosed in conjunction with any subsequent disclosure of the disputed information.

5. 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.

6. 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. 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 at the top of this Notice of Privacy Practices.

D. 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. We will also post the current notice on our website.

E. Complaints

If you have any questions regarding this notice of privacy practice, if you require additional information, or you believe your privacy rights have been violated, please contact our Privacy Officer at:

Newport Orthopedic Institute
HIPAA PRIVACY OFFICER
4950 Barranca Parkway, Suite 207
Irvine, CA 92604
(949) 262-9700

No action will be taken against you and you will not be penalized in any way for filing a complaint with us.

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to:

Region IX
Office for Civil Rights
U.S. Department of Health & Human Services
90 7th Street, Suite 4-100
San Francisco, CA 94103
(415) 437-8310; (415) 437-8311 (TDD)
(415) 437-8329 FAX

OCRMail@hhs.gov

The complaint form may be found at www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaint.pdf. You will not be penalized in any way for filing a com