



SOUTHMAIN

# REJUVENATION INSTITUTE

A MEDICAL GROUP

SAN JOSE ♦ SAN FRANCISCO ♦ BEVERLY HILLS  
 Provider of APOLINAR® Skincare

Apolinar F. Tiongson, M.D.  
 Medical Director

**CONFIDENTIAL  
 PERSONAL INFORMATION**

Please print legibly using blue or black ink

**Date**

Today		Date of Birth		Office Use Only	
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**Name**

Last		First		Middle	
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**Address**

Street		Unit #		City		State		Zip	
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**Contact Information**

Main Phone		Alternate Phone		Email Address	
	CELL/WORK/HOME(Circle one)		CELL/WORK/HOME(Circle one)		

**Optional Information**

Occupation		Self employed	YES / NO Circle one	Employer If not self	
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**How did you hear about us?**

Newspaper Magazine	Please name	
Friends / Relatives	Please name	
Others	Please name	

PLEASE COMPLETE THE FOLLOWING 2 PAGES

How do you rate your facial skin? Please check

<input type="checkbox"/>	OILY	<input type="checkbox"/>	NORMAL	<input type="checkbox"/>	COMBINATION
<input type="checkbox"/>	DRY	<input type="checkbox"/>	SENSITIVE	<input type="checkbox"/>	NONE OF THE ABOVE

Skin conditions and problems:

Check below	Condition	List where (Face, Cheek, Chin, Neck, Chest, Back, Arms, Legs, Etc).
<input type="checkbox"/>	Pigmentation problems	
<input type="checkbox"/>	Acne	
<input type="checkbox"/>	Acne scarring	
<input type="checkbox"/>	Wrinkles	
<input type="checkbox"/>	Pimples	
<input type="checkbox"/>	Enlarged pores	
<input type="checkbox"/>	Blackheads	
<input type="checkbox"/>	Whiteheads	
<input type="checkbox"/>	Unwanted Hair	
<input type="checkbox"/>	Others: (Describe)	
<input type="checkbox"/>		
<input type="checkbox"/>		

What specific areas do you want treated? Please check.

<input type="checkbox"/>	Face	<input type="checkbox"/>	Neck	<input type="checkbox"/>	Chest
<input type="checkbox"/>	Hands	<input type="checkbox"/>	Arms	<input type="checkbox"/>	Legs
<input type="checkbox"/>	Back	<input type="checkbox"/>	Thighs	<input type="checkbox"/>	Others: _____

Name: \_\_\_\_\_

Allergies:

List skin care products you are allergic to:	_____
	_____
List medications, food and others you are allergic to:	_____
	_____

Product used:

Facial skin care products you are presently using including sunscreen.	_____
	_____
Facial skin care products you have used in the past two years, if different from above.	_____
	_____

PLEASE CHECK YES OR NO

		Y	N
	Have you ever seen a doctor for your skin?		
	Have you taken or are you taking Accutane?		
	Do you get cold sores and/or fever blisters on the lips or face?		
	Do you burn due to sun exposure?		
	Do you tan easily?		
	Do you currently sunbathe		
	Do you have history of skin cancer?		
	Do you use sunscreen when exposed to the sun?		
	Do you wear protective clothing when exposed to the sun?		
Women only	Have you taken or are you taking birth control pills?		
	Are you or were you on hormonal replacement therapy?		
	Are you actively trying to become pregnant?		
	Are you pregnant or breastfeeding		
	During pregnancy did you develop masking or hyperpigmentation?		

Signature:

	Name & relation to patient (if minor)	
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Medical Director

(Office Use Only)

DOCTOR'S  
RECOMMENDATION

Date Today	
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Name

Last		First		Middle	
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Patient/Client requests:

	AT-HOME SKIN REJUVENATION PROGRAM	Site/s:
	PROCEDURES	Specify:
	OTHERS	Specify:

Suggestions:

	AT-HOME SKIN REJUVENATION PROGRAM <input type="checkbox"/> For Normal Skin <input type="checkbox"/> For Acneic/Oily Skin <input type="checkbox"/> For Hyperpigmented Skin	Site/s:
	PROCEDURES	Specify:
	OTHERS	Specify:

NOTES:

Physician/Provider Signature:



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Please review this notice carefully.  
Effective: May 1, 2008

## Notice of Privacy Practices

As required by the privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

**This notice describes how health information about you (as a patient) may be used and disclosed and how you can get access to your individually identifiable health information.**

### A. Our commitment to your privacy:

**SouthMain Rejuvenation Institute (SRI)** is dedicated to maintaining the privacy of your individually identifiable health information (also called *protected* health information, or PHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in SRI concerning your PHI. By federal and state law, we must follow the terms of the Notice of Privacy Practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your PHI,
- Your privacy rights in your PHI,
- Our obligations concerning the use and disclosure of your PHI.

**The terms of this notice apply to all records containing your PHI that are created or retained by SRI. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that SRI has created or maintained in the past, and for any of your records that we may create or maintain in the future. SRI will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.**

### B. If you have questions about this Notice, please contact:

Louella D. Eischen  
Director of Operations  
SouthMain Rejuvenation Institute  
Email: [louella.eischen@gmail.com](mailto:louella.eischen@gmail.com)  
(408) 347-1000

### C. We may use and disclose your PHI in the following ways:

The following categories describe the different ways in which we may use and disclose your PHI.

- **Treatment.** SRI may use your PHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your PHI in order to write a prescription for you, or we might disclose your PHI to a pharmacy when we order a prescription for you. Many of the people who work for SRI – including, but not limited to, our doctors and nurses – may use or disclose your PHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your PHI to others who may assist in your care, such as your spouse, children or parents. Finally, we may also disclose your PHI to other health care providers for purposes related to your treatment.

- **Payment.** SRI may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your PHI to bill you directly for services and items. We may disclose your PHI to other health care providers and entities to assist in their billing and collection efforts.
- **Health care operations.** SRI may use and disclose your PHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, SRI may use your PHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for SRI. We may disclose your PHI to other health care providers and entities to assist in their health care operations.
- **Appointment reminders.** SRI may use and disclose your PHI to contact you and remind you of an appointment.
- **Treatment options.** SRI may use and disclose your PHI to inform you of potential treatment options or alternatives.
- **Health-related benefits and services.** SRI may use and disclose your PHI to inform you of health-related benefits or services that may be of interest to you.
- **Release of information to family/friends.** SRI may release your PHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a baby sitter take their child to the pediatrician's office for treatment of a cold. In this example, the baby sitter may have access to this child's medical information.
- **Disclosures required by law.** SRI will use and disclose your PHI when we are required to do so by federal, state or local law.

#### **D. Use and disclosure of your PHI in certain special circumstances:**

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

- **Public health risks.** SRI may disclose your PHI to public health authorities that are authorized by law to collect information for the purpose of:
  - Maintaining vital records, such as births and deaths,
  - Reporting child abuse or neglect,
  - Preventing or controlling disease, injury or disability,
  - Notifying a person regarding potential exposure to a communicable disease,
  - Notifying a person regarding a potential risk for spreading or contracting a disease or condition,
  - Reporting reactions to drugs or problems with products or devices,
  - Notifying individuals if a product or device they may be using has been recalled,
  - Notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information,
  - Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.
- **Health oversight activities.** SRI may disclose your PHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.
- **Lawsuits and similar proceedings.** SRI may use and disclose your PHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your PHI in response to a discovery request, subpoena or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.
- **Law enforcement.** We may release PHI if asked to do so by a law enforcement official:
  - Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement,
  - Concerning a death we believe has resulted from criminal conduct,
  - Regarding criminal conduct at our offices,
  - In response to a warrant, summons, court order, subpoena or similar legal process,
  - To identify/locate a suspect, material witness, fugitive or missing person,

- In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator).
- **Deceased patients.** SRI may release PHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.
- **Organ and tissue donation.** SRI may release your PHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.
- **Research.** SRI may use and disclose your PHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your PHI for research purposes **except** when an Internal Review Board or Privacy Board has determined that the waiver of your authorization satisfies all of the following conditions:
  - The use or disclosure involves no more than a minimal risk to your privacy based on the following: (i) an adequate plan to protect the identifiers from improper use and disclosure; (ii) an adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); and (iii) adequate written assurances that the PHI will not be re-used or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be permitted;
  - The research could not practicably be conducted without the waiver,
  - The research could not practicably be conducted without access to and use of the PHI.
- **Serious threats to health or safety.** SRI may use and disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.
- **Military.** SRI may disclose your PHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
- **National security.** SRI may disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to federal and national security activities authorized by law. We also may disclose your PHI to federal officials in order to protect the president, other officials or foreign heads of state, or to conduct investigations.
- **Inmates.** SRI may disclose your PHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.
- **Workers' compensation.** SRI may release your PHI for workers' compensation and similar programs.

#### E. Your rights regarding your PHI:

You have the following rights regarding the PHI that we maintain about you:

- **Confidential communications.** You have the right to request that SRI communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to **[insert name or title and telephone number of a person or office to contact for further information]** specifying the requested method of contact, or the location where you wish to be contacted. SRI will accommodate **reasonable** requests. You do not need to give a reason for your request.
- **Requesting restrictions.** You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your PHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. **We are not required to agree to your request;** however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your PHI, you must make your request in writing to

**[insert name or title and telephone number of a person or office to contact for further information]**. Your request must describe in a clear and concise fashion:

- The information you wish restricted,
  - Whether you are requesting to limit SRI's use, disclosure or both,
  - To whom you want the limits to apply.
- **Inspection and copies.** You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to **[insert name or title and telephone number of a person or office to contact for further information]** in order to inspect and/or obtain a copy of your PHI. SRI may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. SRI may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.
  - **4. Amendment.** You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for SRI. To request an amendment, your request must be made in writing and submitted to **[insert name or title and telephone number of a person or office to contact for further information]**. You must provide us with a reason that supports your request for amendment. SRI will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the PHI kept by or for SouthMain Rejuvenation Institute; (c) not part of the PHI which you would be permitted to inspect and copy; or (d) not created by SRI, unless the individual or entity that created the information is not available to amend the information.
  - **5. Accounting of disclosures.** All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures SRI has made of your PHI for purposes not related to treatment, payment or operations. Use of your PHI as part of the routine patient care in SRI is not required to be documented – for example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to **[insert name or title, and telephone number of a person or office to contact for further information]**. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but SRI may charge you for additional lists within the same 12-month period. SRI will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.
  - **6. Right to a paper copy of this notice.** You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact **[insert name or title and telephone number of a person or office to contact for further information]**.
  - **7. Right to file a complaint.** If you believe your privacy rights have been violated, you may file a complaint with SRI or with the Secretary of the Department of Health and Human Services. To file a complaint with SRI, contact **[insert name or title and telephone number of the contact person or office responsible for handling complaints]**. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**
  - **8. Right to provide an authorization for other uses and disclosures.** SRI will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time *in writing*. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. *Please note:* we are required to retain records of your care.

Again, if you have any questions regarding this notice or our health information privacy policies, please contact **Louella D. Eischen, Director of Operations, (408) 347-1000 for further information.**



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## HIPAA ACKNOWLEDGMENT

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

You may be contacted by this office to remind you of any appointments, healthcare treatment options or other health services that may be of interest to you. (Circle **Yes** or **No**)

May we contact you at home?	<b>Y / N</b>	Tel. (____)_____	OK to leave Voice mail <b>Y / N</b>
May we contact you at work?	<b>Y / N</b>	Tel. (____)_____	OK to leave Voice Mail <b>Y / N</b>
May we contact you via cell phone?	<b>Y / N</b>	Tel. (____)_____	OK to leave Voice mail <b>Y / N</b>
May we contact email?	<b>Y / N</b>	Tel. (____)_____	

Comment: \_\_\_\_\_

Can a message be left with our company name and what the call is in reference to? **Yes / No**

Is there anyone we can leave a message with? **Y / N** (If yes, please list first and last names)

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

Would you like to authorize an individual as your personal representative? This person would have the authority to schedule, confirm or change appointments only. **Y / N** (If yes, please list first and last names)

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

Occasionally, there may be information that we would like to share with you. Can you:

Receive mail from our office?	<b>Y / N</b>	Mailing _____
Receive promotional email from our office?	<b>Y / N</b>	Address: _____
		Email address: _____

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

SouthMain Rejuvenation Institute has provided me with a copy of my rights as a patient under the HIPAA Act. I have been provided the opportunity to read and understand my rights and ask questions regarding my rights and receive answers to my satisfaction.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_