Dear Toiyabe Patient,

Toiyabe Indian Health Clinic is transitioning to a new Electronic Health Record (EHR) system – NextGen!

NextGen is a leading healthcare solutions provider on a relentless quest to improve the lives of the patients who get care from a clinic using NextGen. What this means is that Toiyabe will soon be changing from our current EHR to NextGen for better record keeping which will mean better patient care.

To ensure that this change is successful, Toiyabe will be asking each of our patients to complete a patient registration packet (included with this letter). Additionally, Toiyabe is asking our patients to provide a copy of the following:

- Government Issued ID (Driver's License, etc)
- Social Security Card
- Current Insurance Card – Provide address associated with the insurance card, if different than what is on Driver's License
- If Native American, Tribal ID

This is a big, positive change for Toiyabe. It is a change that we have been working on since 2017, and a change that is long overdue. Healthcare delivery can be very complex, and having a robust EHR is essential to ensure that we provide the very best care we can. We appreciate your help with this transition, and we look forward to continuing to serve you.

Please complete the enclosed Registration Packet and return to one of our clinics:

Bishop: 250 N See Vee Ln, Bishop, CA 93514

Lone Pine: 1150 S Goodwin Rd, Lone Pine, CA 93545

Bridgeport: 199 Twin Lakes Rd, Bridgeport, CA 93517

Thank you very much for helping make this a success,

Ethan Dexter

Chief Operating Officer

Toiyabe Indian Health Clinic

Toiyabe Indian Health Project

Patient Registration Form

Patient information

First name: ______ Middle name: ______ Last name: ______

Birth Date: ☐☐ - ☐☐ - ☐☐☐☐

SSN: ☐☐☐-☐☐-☐☐☐☐

Gender Details:

Birth sex *(Select any ONE)*

☐ Male ☐ Female ☐ Undifferentiated ☐ Unknown

Current Gender *(Select any ONE)*

☐ Male ☐ Female ☐ Undifferentiated ☐ Unknown

Preferred Name

______

Preferred Pronoun *(Select any one)*

☐ He, Him, His ☐ She, Her, Hers ☐ Decline to Answer

☐ They, Them, ☐ Theirs ☐ Other

Billing Address:

Address Line 1: ______ Address Line 2: ______

City: ______ State: ☐☐ Zip code: ☐☐☐☐☐☐☐☐☐

Cell phone: ☐☐☐ ☐☐☐ ☐☐☐☐ Home phone ☐☐☐ ☐☐☐ ☐☐☐☐ Day/Work phone: ☐☐☐ ☐☐☐ ☐☐☐☐

Email: ______ @ ______

Do you reside on the reservation? Yes ☐ No ☐

Primary Insurance:

Plan Name ______ Insured's Name ______

Insured's SSN ______ Insured's DOB ______

Policy/ID ______ Group # ______ Effective Date ______

Claims Address & Phone Same as Billing Address Yes ☐ No, Please Specify Below

______

Secondary Insurance:

Plan Name | Insured's Name

Insured's SSN | Insured's DOB

Policy/ID | Group # | Effective Date

Claims Address & Phone | Same as Billing Address | Yes ☐ | No, Please Specify Below

Tertiary Insurance:

Plan Name | Insured's Name

Insured's SSN | Insured's DOB

Policy/ID | Group # | Effective Date

Claims Address & Phone | Same as Billing Address | Yes ☐ | No, Please Specify Below

Guarantor Information:

If same as billing check box ☐

Relationship of Guarantor to Patient: Self ☐ Spouse ☐ Parent ☐ Other

Guarantor SSN

Address Line 1:

Address Line 2:

City:

State:

Zip code

Cell phone

Home phone

Day/Work phone

Email: @

NOTE TO STAFF: Any information entered in *Other field need to be entered manually in PM screen.

Ethnicity: ***(Select any ONE)***

☐ Hispanic or Latino ☐ Not Hispanic or Latino

☐ Declined to specify ☐ Unknown

*Other:

Race: *(Check* ***ALL*** *that applies*

(Race Order

☐ American Indian or Alaska Native

☐ Asian

☐ Black or African American

☐ Native Hawaiian or Other Pacific Islander

☐ White

☐ Declined to specify

*Other: ______

Please Specify Affiliated Tribe in the box below

______

Please Attach Tribal Information for Specified Affiliation

Marital Status: *(Select any* ***ONE)***

☐ Married	☐ Separated	☐ Domestic Partner	☐ Interlocutory
☐ Divorced	☐ Life Partner	☐ Married	☐ Polygamous
☐ Single	☐ Unknown	☐ Widowed	

Emergency Contact Information:

First name: ______ Middle name: ______ Last name: ______

Address 1: ______ Address 2: ______

City: ______ State: ______ Zip code: ______

Cell Phone: ___-___-____ Home phone: ___-___-____ Work phone: ___-___-____

Relationship:

☐ Mother	☐ Guardian	☐ Spouse
☐ Father	☐ Grandparent	☐ Significant Other
☐ Sister	☐ Grandchild	☐ Life Partner
☐ Brother	☐ Nephew or niece	☐ Friend
☐ Child, Mother is the patient	☐ Child, Father is the patient	☐ Other

Preferred Language: *(Select any* ***ONE)***

☐ English	☐ Spanish	☐ Chinese	☐ French
☐ Vietnamese	☐ Korean	☐ German	☐ Arabic
☐ Russian	☐ Declined to specify		

*Other: ______

Information for Minors & Children Only:

With my Signature below, I hearby grant permission to the listed & named adults who, in my absence, may accompany and make any and/ or all decisions regarding treatment needed for my minor/child.

Name/Relationship to Patient	Name/Relationship to Patient
Signature of Patient/Responsible Party	Signature of Patient/Responsible Party

TOIYABE INDIAN HEALTH PROJECT, INC

Chronic Pain Management Policy

To Whom It May Concern:

Due to the high demand for patients desiring pain management at Toiyabe Indian Health Clinic, we have decided not to accept any more patients for chronic pain management. Our system is becoming overwhelmed and we are unable to provide the level of service that chronic pain management requires. We would be happy to provide for your other primary care needs. However, we will not be doing chronic pain management.

Please sign below to acknowledge that you have read this statement and understand it:

Patient Signature____

Date____

Sincerely,

Dr Summer Frazier, Medical Director
Toiyabe Medical Department
Toiyabe Indian Health Project, Inc

TOIYABE INDIAN HEALTH PROJECT, INC.
Cancellation, No Show, and Late Arrival Policy
Acknowledgement of Receipt

By signing this form, you acknowledge receipt of the *Cancellation, No Show, and Late Arrival Policy.* We encourage you to read it in full.

I acknowledge receipt of the *Cancellation, No Show, and Late Arrival Policy* of *Toiyabe Indian Health Project, Inc.*

Patient Name (Printed): ______________________________________

Signature: ______________________________________

Date: ______________________________________

If not signed by patient, please indicate relationship:

[ ] Parent or Guardian of minor patient

[ ] Guardian or conservator of an Incompetent patient

[ ] Other authorized personal representative of patient

INABILITY TO OBTAIN ACKNOWLEDGEMENT

To be completed only if no signature is obtained. If it is not possible to obtain the individual's acknowledgment. describe the good faith efforts made to obtain the individual's acknowledgement, and the reason why the acknowledgement was not obtained.

Signature of provider representative: ______________________

Date: __________________

TOIYABE INDIAN HEALTH PROJECT, INC.

Cancellation, No Show, and Late Arrival

In order to reduce the number of cancellations, no-shows and late arrivals, the following policy will be followed:

- All appointments will be confirmed in person, by phone, or e-mail by a staff member one day prior to the scheduled appointment or on Friday for a Monday appointment.
- The patient will be instructed to arrive 10-20 minutes early for a routine care appointment and ½ hour early for a new patient appointment. The patient will be reminded to bring insurance, Medicaid information and co-payment if applicable.
- Cancellations should be made 24 hours in advance or as early as possible before of the appointment. Patients calling in to cancel before their appointment will be rescheduled if desired.

Patients who fail to keep a scheduled appointment without notifying the office 24 hours before the appointment will be recorded as a no-show. An appointment is considered to have been missed if any of the following occur:

1. The patient fails to show up for a scheduled appointment.
2. The patient presents more than five (5) minutes late for a scheduled appointment.
3. The patient calls to cancel a scheduled appointment with less than twenty-four (24) hours advance notice from scheduled appointment date.

Patients who accumulate three missed appointments in a six (6)-month period will not be allowed to schedule any future routine care appointments for a period of four (4) months following the third missed appointment. All services will continue to be available as walk-in only appointments during the four-month period, and patients will be seen at first availability once they are in clinic. Also, transportation services are not available to any patient who has been restricted from making appointments.

Effective Date: September 1, 2021

TOIYABE

DENTAL PATIENT MEDICAL HISTORY

Patient Name: __________________ DOB: _________ Ph# _______

If you are unsure how to answer any of the questions below, please ask the dental staff for help.

Do you or have you had any of the following? (Please check)

	YES	NO		YES	NO
Organ transplant Date:			Epilepsy, seiiures, or nervous system disease		
Joint replacement (hip, knee, etc.)Date:			Stroke		
Artificial (prosthetic) heart valves Date:			Allergy to (cirde) *metal I local anesthetics*		
Congenital Heart Disease, defect, or heart murmur			Cancer/tumors Dates:		
Bacterial Endocarditis (SBE)			Chemotherapy or radiation Dates:		
Kidney problems or dialysis (circle)			Tuberculosis (circle) *CURRENT/ IN PAST*		
Spleen removed			Asthma or other lung disease		
Steroid use (e.g. prednisone) Date:			Ulcers or GERO		
HIV or AIDS, do you believe you have been exposed			Taken or scheduled for IV bisphosphonates		
Lupus (SLE)			Medications for osteoporosis (e.g. Boniva/Fosamax)		
Rheumatoid Arthritis			Thyroid problems (circle) *HIGH/ LOW*		
Diabetes (drde) *TYPE I / TYPE II*			Physical or mental disability that requires consideration		
Other immunosuppressive condition			Chemical dependency (alcohol/other drugs)		
Hepatitis (circle) *TREATED/ CURRENT* Type:			Do you chew tobacco or smoke tobacco or marijuana?		
Other liver disease			If yes, how much and are you interested in quitting?		
Pacemaker/artificial device /implant Date:					
Congestive heart failure			Any previous problems with opioids or pain medication		
Heart attack					
Chest pain / Angina			Women Only		
High blood pressure			Are you pregnant		
Do you take blood thinners?			Are you nursing		
Anemia or abnormal bleeding or bruising			Are you taking birth control (antibiotics counteract bcp)		

List any medications that you are allergic to and what type of reaction: ____________________

Has a doctor recommended that you take antibiotic prior to dental treatment? ________________

List medications you currently take {including over the counter): ____________________

Date of last medical appointment: __________ Primary care provider name: _________

Have you ever been hospitalized? __________ When and what for: ____________

Do yciu have any disease, condition, or problem not listed: YES/ NO (if yes specify) _____________

The answers I have given above are true to the best of my knowledge.

Slg ature (Patient or ;uardlan If patient ls a minor) Date

TOIYABE INDIAN HEALTH PROJECT, INC.
250 SEE VEE LANE
BISHOP, CALIFORNIA 93514

ADMINISTRATION
(760) 873-8464
(760) 873-3935 FAX

FISCAL
(760) 873-6111
(760) 872-8152 FAX

CONTRACT CARE
(760) 873-6111
(760) 873-7601 FAX

OPTICAL
(760) 873-6111

BISHOP MEDICAL CLINIC
(760) 873-8461
(760) 873-3908 FAX

PHARMACY
(760) 873-4721
(760) 873-6127 FAX

DENTAL
(760) 873-3443
(760) 873-3889 FAX

COMMUNITY HEALTH/
NUTRITION/ELDERS
(760) 872-2622
(760) 873-6362 FAX

PREVENTIVE MEDICINE
(760) 873-8851
(760) 873-4922 FAX

FAMILY SERVICES DEPARTMENT
(760) 873-6394
(760) 873-3254 FAX

DIALYSIS CENTER
(760) 873-7611
(760) 873-3361 FAX

WIC PROGRAM
(760) 872-3707
(760) 873-6362 FAX

LONE PINE COMMUNITY CLINIC
1150 S. GOODWIN LANE
P. O. BOX 186
LONE PINE, CA 93545
(760) 876-4795
(760) 876-5624 FAX

COLEVILLE CLINIC
73 CAMP ANTELOPE RD.
COLEVILLE, CA 96107
(530) 495-2100
(530) 495-2122 FAX

Dental Material Fact Sheet Acknowledgement Form

California has passed a law mandating that dental offices provide patient with a dental materials fact sheet. New and existing patients need to be given the pamphlets and sign and acknowledgment that they received it. Please discuss any questions about any materials you may have with your Dentist.

I, ____ have a copy of the dental Materials fact sheet as required by law.

____

Patient Signature **Date**

TOIYABE INDIAN HEALTH PROJECT, INC.
Notice of Privacy Practices
Acknowledgement of Receipt

By signing this form, you acknowledge receipt of the Notice of Privacy Practices of Toiyabe Indian Health Project, Inc. Our Notice of Privacy Practices provides information about how we may use and disclose your protected health information. We encourage you to read it in full. Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by: contacting our facility at 760-873-8461 or 760-873-8464.

I acknowledge receipt of the Notice of Privacy Practices of Toiyabe Indian Health Project, Inc.

Patient Name ____

Signature ____

Date ____

If not signed by patient, please indicate relationship:

☐ Parent/Guardian

☐ Guardian or conservator of an incompetent patient

☐ Other authorized personal representative of patient

INABILITY TO OBTAIN ACKNOWLEDGEMENT

To be completed only if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement, and the reason why the acknowledgement was not obtained:

Signature of Provider

Date: ______________________________

If you have any questions about our Notice of Privacy Practices, please contact:

Quality Improvement/Compliance Department: (760) 873-8464 extension 343

Toiyabe Indian Health Project, Inc.

NOTICE OF PRIVACY PRACTICES

Effective Date: ***April 14, 2003***
Revised: **September 23, 2013**

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE REVIEW IT CAREFULLY

If you have any questions about this notice, please contact
Privacy Officer, (760) 873-8464

WHO WILL FOLLOW THIS NOTICE

This notice describes our facilities practices and that of:

- Any health care professional authorized to enter information into your client health record (medical, dental, child & family services, outreach, behavioral health, and dialysis).
- All departments
- Any member of a volunteer group we allow to help you while you are a client of our facility.
- All employees, staff and other authorized facility personnel.
- All our sites and locations follow the terms of this notice. In addition, these sites and locations may share medical information with each other for Treatment and payment purposes described in this notice.

OUR PLEDGE REGARDING HEALTH INFORMATION:

We understand that health information about you and your health is personal. We are committed to protecting health information about you. We create a record of the care and services you receive at our facility. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by the staff and consultants of our facility.

This notice tells you about the ways in which we may use and disclose health information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of health information.
We are required by law to:

- make sure that health information that identifies you is kept private (with certain exceptions);
- give you this notice of our legal duties and privacy practices with respect to health information about you; and
- follow the terms of the notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:

The following categories describe different ways that we use and disclose health information. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

- **For Treatment.** We may use health information about you to provide you with health treatment or services. We may disclose health information about you to doctors, nurses, technicians, dentists, psychologist, students or other clinic personnel who are involved in taking care of you at our facility. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. In addition, the doctor may need to tell the dietitian / nutritionist if you have diabetes so that we can provide you with the proper patient education needs. Different department of our facility also may share health information about you in order to coordinate the different things you need, such as prescriptions, lab work, x-rays, and referrals for consults or care outside our facility. We also may disclose health information about you to people outside our facilities who may be involved in your health care after you leave our facility, such as family members, visiting nurses or other we use to provide services that are part of your care.

- **For Payment.** We may use and disclose health information about you so that the treatment and services you receive at our facility may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to give your health plan information about your clinic visit and services you received so your health plan will pay us or reimburse you for the visit. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover treatment.

  We may disclose health information about you so that we may pay for treatment and services you received as an eligible individual under our Indian Health Services contract (i.e. Contract Health Services). For example, we may request information about you when we are paying another provider or for services provided to you. We will also give information about eligible individuals to the Indian Health Service as required of our contract with that agency.

- **For Health Care Operations.** We may use and disclose health information about you for our operations. These uses and disclosures are necessary to run the facility and make sure that all of our patients receive quality care. For example, we may use health information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine health information about many patients to decide what additional services we should offer, what services are not needed, and whether certain new treatments are effective. We may disclose information to doctors, nurses, technicians, students, and other facility personnel for review and learning purposes. We may combine the health information we have with health information for other facilities to compare how we are doing and see where we can make improvements in the care and services we offer. We may remove information that identifies you from this set of health information so others may use it to study health care and health care delivery without learning who the specific patients are. We may also call you by name in the waiting room when the provider is ready to see you. In addition, we may use general demographic data about you when we apply for grant funding.

- **Appointment Reminders.** We may use and disclose health information to contact you as a reminder that you have an appointment for treatment or health care at our facility.

- **Treatment Alternative.** We may use and disclose health information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

- **Health-Related Benefits and Services.** We may use and disclose health information to tell you about health-related benefits or services that may be of interest to you.

- **Individuals Involved in Your Care or Payment for Your Care.** We may release health information about you to a friend or family member who is involved in your care. We may also give information to someone who helps pay for your care, such as IHS. In addition, we may disclose health information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

SPECIAL SITUATION

- **As Required By Law.** We will disclose health information about you when required to do so by federal, state or local law.

- **To Avert a Serious Threat to Health or Safety.** We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent that threat.

- **Business Associates.** We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

- **Organ and Tissue Donation.** If you are an organ donor, we may release health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

- **Military and Veterans.** If you are a member of the armed forces, we may release health information about you as required by military command authorities. We may also release health information about foreign military personnel to the appropriate foreign military authority.

- **Worker's Compensation.** We may release health information about your care for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

- **Public Health Risks.** We may disclose health information about you for public health activities. These activities generally include the following:

    - to prevent or control disease, injury or disability;
    - to report births and deaths
    - to report abuse or neglect of children, elders and dependent adults;
    - to report reactions to medications or problems with products;
    - to notify people of recalls of products they may be using;
    - to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;

- to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

➢ **Health Oversight Activities.** We may disclose information to health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

➢ **Data Breach Notification Activities.** We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information.

➢ **Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request (which may include written notice to you) or to obtain an order protecting the information requested.

➢ **Law Enforcement.** We may release health information if asked to do so by a law enforcement official:

- In response to a court order, subpoena, warrant, summons or similar process;
- To identify or locate a suspect, fugitive, material witness, or missing person;
- About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
- About a death we believe may be the result of criminal conduct;
- About criminal conduct at the facility; and
- In emergency circumstance to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

➢ **Coroners, Medical Examiners and Funeral Directors.** We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release health information about patients of the facility to funeral directors as necessary to carry out their duties.

➢ **National Security and Intelligence Activities.** We may release health information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

➢ **Protective Services for the President and Others.** We may disclose health information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.

➢ **Inmates.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release health information about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

USES AND DISCLOSURES THAT REQUIRE US TO GIVE YOU AN OPPORTUNITY TO OBJECT AND OPT OUT

- **Individuals Involved in Your Care or Payment for your Care.** Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your Protected Health Information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

- **Disaster Relief.** We may disclose your Protected Health Information to disaster relief organization that seeks your Protected Health Information to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you an opportunity to agree or object to such a disclosure whenever we practically can do so.

YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES

The following uses and disclosures of your Protected Health Information will be made only with your written authorization:

1. Uses and disclosures of Protected Health Information for marketing purposes; and

2. Disclosures that constitute a sale of your Protected Health Information

Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will not longer disclose Protected Health Information under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU.

You have the following rights regarding health information we maintain about you:

- **Right to Inspect and Copy.** You or your personal representative has the right to inspect and copy health information that may be used to make decisions about your care. Usually, this includes health and billing records, but may not include some behavioral health information.

  To inspect and copy health information that may be used to make decisions about you, you must submit your request in writing to the receptionist. If you request a copy of the information, ***the first copy will be provided at no charge. The second copy*** we may charge a fee for the costs of copying, mailing or other supplies associated with your request.

  We may deny your request to inspect and copy in certain very limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review. 45 CFR §164.524(a)(3)

- **Right to an Electronic Copy of Electronic Medical Records.** If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide

access to your Protected Health Information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

➢ **Right to Get Notice of a Breach.** You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

➢ **Right to Amend.** If you feel that health information we have about you is incorrect or incomplete, you may ask us to amend the information by submitting additional information in the form of a written addendum. You have the right to request an amendment for as long as the information is kept by or for the facility.

To request and amendment, your request must be made in writing and submitted to the receptionist. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the health information kept by or for the facility;
- Is not part of the information which you would be permitted to inspect and copy; or
- Is accurate and complete.

➢ **Right to an Accounting of Disclosure.** You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of health information about you other than our own uses for treatment, payment and health care operations, (as those functions are described above) and with other expectations pursuant to the law.

To request this list or accounting of disclosures, you must submit your request in writing to the receptionist. Your request must state a time period that may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

➢ **Right to Request Restrictions.** You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example you could ask that we not use or disclose information about a Behavioral Health Service you had.

We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

To request restrictions, you must make your request in writing to the receptionist. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse. We are not required to agree to your request unless you are asking us to restrict the use and disclosures of your Protected Health information to a health plan for

payment or health care operations purposes and such information you with to restrict pertains solely to a health care item or service for which you have paid us "out-of-pocket" in full. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

- **Out-of-Pocket Payments.** If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

- **Right to Request Confidential Communications.** You have the right to request that we communicate with you about health matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

  To request confidential communications, you must make your request in writing to the receptionist. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

- **Right to a Paper Copy of This Notice.** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

To obtain a paper copy of the most current notice contact: **Privacy Officer**.

CHANGES TO THIS NOTICE

- We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for health information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in each of our facilities. The notice will contain on the first page, in the top right-hand corner, the effective date. In addition, each time you register at one of our facilities for treatment or health care serves, we will offer you a copy of the current notice in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with our program or with the Director of the Office for Civil Rights, US Department of Health & Human Services, 200 Independence Ave. Room 509F, HHH Bldg., Washington, DC, 20201. To file a complaint with us, contact ***Privacy Officer, (760) 873-8464***. All complaints must be submitted in writing.

You will not be penalized for filing a complaint.

OTHER USES OF MEDICAL INFORMATION

Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.