CONSENT TO TREATMENT

NATURE OF SERVICES: I understand that as a Federally Qualified Health Center (FQHC), Opsam Health provides comprehensive primary healthcare services, including but not limited to preventive care, chronic disease management, behavioral health services, and dental services.

PURPOSE OF TREATMENT: I understand that receiving healthcare services from Opsam Health aims to promote and maintain my overall health and well-being, prevent, and manage diseases, and address any current health concerns.

CONFIDENTIALITY AND PRIVACY: I understand that my health information will be treated as confidential and will be protected in accordance with applicable laws and regulations. I authorize Opsam Health to use and disclose my health information for treatment, payment, and healthcare operations as outlined in their Notice of Privacy Practices.

TREATMENT RISKS AND BENEFITS: I understand that every medical procedure, treatment, or intervention carries certain risks and benefits. The healthcare provider will explain the potential risks and benefits of any proposed treatment or procedure, and I have the right to ask questions to ensure my understanding.

ALTERNATIVE: I understand that I have the right to be informed of any reasonable alternatives to the proposed treatment, including any alternative procedures, therapies, or medications that may be available. I have the right to discuss these alternatives with my healthcare provider and make an informed decision regarding my care.

FINANCIAL RESPONSIBILITY: I understand that I am responsible for any changes or fees associated with the healthcare services provided by Opsam Health. I agree to cooperate with Opsam Health to promptly address any financial obligations and provide accurate insurance information, if applicable.

SAN DIEGO HEALTH CONNECT (SDHC): I authorize the transfer of my health information to SDHC and that I can opt out of SDHC at any time by notifying Opsam Health staff.

CONSENT TO TREATMENT: I hereby give my informed consent to Opsam Health and its healthcare providers to administer necessary healthcare services, treatments, procedures, and medications as they deem appropriate for my care. I understand that I have the right to refuse or withdraw consent at any time, and it will not affect my right to future care or treatment.

CONSENT TO TREATMENT OF A MINOR (IF APPLICABLE): As the parent or legal guardian with authority to consent on behalf of the minor child named below, I hereby give my consent to the treatment of the minor from the staff associated with/or employment by Opsam. The proposed treatment plan has been explained to me, the general nature and extent of the risks involved, and alternative treatment options, if any. This consent will be valid until the minor reaches the age of 18.

I have had the opportunity to read and understand this Consent Form, and I have discussed my questions and concerns with my healthcare provider. By signing below, I acknowledge that I am providing my informed consent to receive healthcare services from Opsam Health.

Patient Name: ____________________ **Patient/Parent /Guardian/Conservator Signature:** ____________________

Relationship to Patient: ______________________ **Date:** ________________________ **Time:** ________________

Witness Name: ___________________________ **Witness Signature:** ____________________________

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY PRACTICES

We are committed to protecting your personal health information in compliance with the law. The attached Notice of Privacy Practices states:

- Our obligations under the law with respect to your personal health information.
- How we may use and disclose the health information that we keep about you.
- Your rights relating to your personal health information.
- Our rights to change our Notice of Privacy Practices.
- How to file a complaint if you believe your privacy rights have been violated.
- The conditions that apply to uses and disclosures not described in this notice.
- The person to contact for further information about our privacy practices.

We are required by law to make available to you a copy of this Notice and to obtain your written acknowledgment that you have reviewed and/or received a copy of this Notice.

PATIENT ACKNOWLEDGMENT OF RECEIPT

I, ____ , hereby acknowledge that:

☐ I have reviewed the Notice of Privacy Practices.
☐ I have received a copy of the Notice of Privacy Practices.

____ ____________________
Signature of Patient Date

____ ____________________
Signature of Parent or Patient's Representative (if applicable) Date

____
Description of Legal Authority to Act on Behalf of Patient

OPSAM HEALTH
Caring for the Community Since 1973

PATIENT CONDUCT AGREEMENT

This agreement is between the ______________________________ (Patient Name) and OPSAM HEALTH.

In an effort to better care for you, the following expectations are required to maintain an effective provider-patient relationship and to ensure that a safe clinic environment is maintained for you and for the staff.

By signing below, I acknowledge that my continued care at OPSAM HEALTH is contingent upon the following expectations:

1. I will not engage in verbal threats or any aggressive behavior with the staff, providers, or other patients in-person, on videoconference or by telephone.
2. I will not use any language that may be offensive to staff or other patients based on race, religion, appearance, gender, or sexual orientation.
3. I will not use intoxicating or illicit substances on any OPSAM HEALTH grounds.
4. I will not steal or conduct any illegal activities in the office.
5. I will not invade the privacy of other patients.

In return, I acknowledge that OPSAM HEALTH staff and providers agree to the following:

1. To meet my needs to the best of their ability given the resources available.
2. To communicate with me in a professional and respectful manner.
3. To address my inquiries related to my health in a timely manner.
4. To effectively communicate with me any delay in my appointment time.
5. To review my grievances timely and always discuss with me proposed resolution to the matter.

Failure to comply with the above agreement may result in your being asked to leave the clinic for the day. This will be immediately followed by a warning letter sent to your address on file and will be attached to your records. If the conduct is repeated, a formal dismissal from care will be reviewed and initiated. If care is terminated, you will have access to care for urgent medical issues for 30 days following the date of termination to allow you sufficient time to gain access to care with another facility. It is your responsibility to establish care with another provider during this 30-day period.

Initial

1. ________ I have read and understand the above-listed behavioral expectations. I also understand that failure to meet these expectations may result in termination of the relationship between me And this provider/organization.
2. ________ I have received a copy of the practice's "Patient Rights and Responsibilities" policy.

Patient/Family/POA signature: ______________________________ **Date:** ____________________

Provider signature/number: ______________________________ **Date:** ____________________

Witness signature: ______________________________ **Date:** ____________________

PATIENT PORTAL AUTHORIZATION

The Patient Portal is designed to improve physician and patient communication. Once you are registered as a patient and have provided us with your secure email, you will be assigned a username and password.

After you register with the Patient Portal, you will be able to:

- Update your contact information.
- Request your own appointments.
- Communication of laboratory results from staff to patient.
- Request prescription refills.
- View your medical summary, medication list, treatment history, and visitation dates.
- Receive reminders through your email.
- View current and past statements.

The following will **NOT** be accepted through Patient Portal:

- Receiving advice on the best course of treatment for your medical problem. All diagnosis will be made by your provider when you are seen for an office visit.
- Request for narcotics/controlled medications.
- Request for refill for medication not currently being prescribed by an OPSAM Health provider.

Online communications should never be used for life threatening, emergency communications or urgent requests. If you have an emergency or an urgent request, you should contact 911 or your physician via telephone.

Reminders for Patient Portal:

- You will have 6 failed login attempts before the account is locked.
- You will be receiving reminders via email from reminders@eclinicalworks.com regarding your appointments, test results posting , etc.
- Please make security adjustments to your email or computer to receive your emails.
- You will be able to reply to your email reminders from reminders@eclinicalworks.com.
- If you have any questions regarding these emails, please send us a message via the Patient Portal.
- If you forget your password, you may request another one through Patient Portal by clicking on the "Forgot Password" link.
- After you are finished accessing Patient Portal make sure to logout and close your browser. This reduces the risk of someone else accessing your private information.

1428 Highland Avenue, National City, CA 91950 · 844-200-2426 · Fax (619) 356-2726

- Avoid using a public computer to access Patient Portal.
- Patient Portal is provided as a courtesy service for our patients. There is no service fee. However, if the patient abuses or misuses Patient Portal, we reserve the right to terminate the patient's account.
- Our hours of operation are Monday, Tuesday, Thursday, and Friday at 8:30am-5:30pm, Wednesday at 10:00am-7:00pm, and the first and third Saturday from 8:30 am-5:30pm. We encourage you to use the website at any time; however, messages are held for us until we return the next business day. Messages are typically handled within 1 business day.
- If your doctor is out of the office, your request may be held until his or her return.
- We reserve the right to suspend or terminate the Patient Portal at any time and for any reason.

How the Secure Patient Portal Works:

A secure web portal is a type of webpage that uses encryption to keep unauthorized persons from reading communications, information, or attachments. Secure messages and information can only be read by someone who knows the right password or pass phrase to log in to the portal site. Because the connection channel between your computer and the website uses secure sockets layer technology you can read or view information on your computer, but it is still encrypted in transmission between the website and your computer.

Protecting Your Private Health Information and Risks:

This method of communication and viewing prevents unauthorized parties from being able to access or read messages while they are in transmission. No transmission system is perfect. We will do our best to maintain electronic security. However, keeping messages secure depends on two (2) additional factors:

1. The secure message must reach the correct email address, and
2. Only the correct individual (or someone authorized by that individual) must be able to have access to the message.

Only you can make sure these factors are present. It is imperative that our practice has your correct e-mail address and that you inform us of any changes to your e-mail address. You also need to keep track of who has access to your email account so that only you, or someone you authorized, can see the messages you receive from us. You are responsible for protecting yourself from unauthorized individuals learning your password. If you think someone has learned your password, you should promptly go to the website and change it.

Patient Acknowledgement and Agreement:

I acknowledge that I have read and fully understand this consent form and the policies and procedures regarding the Patient Portal that appears at log in. I understand the risks associated with online communications between my physician and me, and consent to the conditions

OPSAM HEALTH

Caring for the Community Since 1973

outlined herein. In addition, I agree to follow the instructions set forth herein, including the Policies and Procedures set forth in the log in screen, as well as any other instructions that my physician may impose to communicate with patients via online communication. I understand and agree with the information that I have been provided.

Print Name: ______________________________ DOB: ______________

Patient's Signature: __________________________ Date: ______________

Complete the following if the email address does not belong to the patient:
(Please note, Patient Portal access is not available for patients under 18 years of age.)

Name of Parent/Guardian requesting to access:

______________________ ______________________ ____________
Last Name First Name MI

__________________________________ ______________
Relationship to Patient Date

1428 Highland Avenue, National City, CA 91950 · 844-200-2426 · Fax (619) 356-2726

Notice of Advance Health Care Directive

California Probate Code Section 4701 Acknowledgement of Receipt

Name: ____

DOB: ____

Acknowledgement of Receipt:

By signing this form, you acknowledge receipt of the Notice of Advance Directive of Operation Samahan, Inc., dba OPSAM Health. This information is about your decision in advance of what medical treatment you want to receive in the event you become physically or mentally unable to communicate your wishes.

If you have any questions or need additional information about our Notice of Advance Directive, please contact our administration office at 844-200-2426.

I acknowledge receipt of the Notice of Advance Directive of Operation Samahan, Inc., dba OPSAM Health.

Signature: ______________________________________ Date: ____________________
(Patient/Parent/Conservator/Guradian

Inability to Obtain Acknowledgment:
To be completed only if no signature is obtained. If it is not possible to obtain the individual's acknowledgment, and the reason why the acknowledgment was obtained.

____ ________________________________
Signature of the Provider Representative Date