OPSAM HEALTH
Caring for the Community Since 1973

Patient Registration Form

Patient Information

Last Name:_____ **First Name**:_____ **Middle Initial**:_____ **Date of Birth**: _____

Previous Name:_____ **Cell Phone Number**:_____ **Home Phone Number**: _____

E-Mail: _____ **Social Security #**:_____

Address

Address:_____ **City**:_____ **State**: _____ **Zip Code**: _____ **County**:_____

Legal Guardian or Financial Party Responsible

Last Name:_____ **First Name**:_____ **Date of Birth**:_____

Address:_____ **City**:_____ **State**:_____ **Zip Code**:_____

Relationship to Patient: _____ **Social Security #**:_____ **Phone Number**:_____

Emergency Contact:

Name:_____ **Phone Number**:_____**Relationship to Patient**:_____

Additional Patient Information

Marital Status: ☐Single ☐Married ☐ Divorced ☐ Widowed ☐Separated

Language: ☐English ☐ Spanish ☐Tagalog ☐Other Language (Specify):_____

Do you require special assistance? ☐None ☐Sign language ☐Language Interpreter ☐Other: _____

Student Status? ☐Full-Time ☐Part-Time ☐Not a student

How can we contact you? ☐Phone ☐Text Message ☐ E-Mail ☐ Post Mail

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Demographics:

Birth Sex: ☐Male ☐Female

Sexual Orientation: ☐Lesbian, Gay or Homosexual ☐Straight or Heterosexual ☐Bisexual ☐ Something Else ☐Don't Know ☐Choose not to Disclose

Gender Identity: ☐Male ☐Female ☐Transgender, Male – Female ☐Transgender, Female – Male

Race: ☐Asian ☐Native Hawaiian/Other Pacific Islander ☐White/Caucasian ☐Black/African American ☐American Indian/Alaska Native ☐More than one race ☐Unreported/Choose not to disclose race

Ethnicity:☐Hispanic, Latino/a or Spanish Origin ☐Puerto Rican ☐Cuban ☐Not Hispanic, Latino/a or Spanish Origin ☐Unreported/Choose not to disclose ethnicity

Homelessness Housing: ☐Shelter ☐Transitional Housing ☐Doubling Up (Temporary and unstable) ☐Street ☐Permanent Supportive ☐Other ☐Unknown

Agricultural Worker (check one): ☐Migrant ☐Seasonal

Military Status: Do you consider yourself a U.S Military Veteran? ☐Yes ☐No

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Signature of Patient/Legal Guardian: _____ **Date:**_____

Name of Patient/Legal Guardian: _____ **Relationship to Patient:**_____

Glossary

Agricultural Worker:

- Migratory agricultural workers: Individuals who work in agriculture and must keep traveling in different regions to have work.
- Seasonal agricultural workers: Individuals who work in agriculture on a seasonal basis and who DO NOT meet the definition of a migratory agricultural worker.

Ethnicity: Someone belonging to a population group or subgroup made up of people who share a common cultural background or descent, can be:

- Hispanic, Latino/a or Spanish Origin: Mexican, Mexican American, Chicano/a, Puerto Rican, Cuban
- Not Hispanic, Latino/a or Spanish Origin
- Unreported/Choose not to disclose ethnicity

Homeless: Describes an individual who does not have safe and secure housing during the night in which the location is unfit for someone to live (e.g., street, field, abandoned building)

Homelessness Housing:

- Shelter: Typically offers a temporary place to sleep and food to those in need, but often has limitations on the number of days or hours that a person can stay there.
- Transitional Housing: A housing solution that assists individuals into permanent housing.
- Doubling Up: Someone who is living with others. The arrangement is temporary and unstable,
- Street: Someone who is living outdoors, in a vehicle, in an encampment, in makeshift housing/shelter, or in other places generally not deemed safe or fit for human occupancy.
- Permanent Supportive: Is in service-rich environments, does not have time limits, and may be restricted to people with some type of disabling condition.
- Unknown: Someone who is known to be experiencing homelessness whose housing situation is unknown.

Military Status: Discharged individuals who served in the active military, naval, or air service, which includes the Air Force, Army, Coast Guard, Marines, Navy, and Space Force, or as a commissioned officer of the Public Health Service or National Oceanic and Atmospheric Administration. This also includes individuals who served in the National Guard or Reserves on active-duty status.

Race: A physical or social categorization of an individual that can be based on inheritance or genetics. Includes:

- Asian: Asian Indian, Chinese, Filipino, Japanese, Korean, Vietnamese, Other Asian
- Native Hawaiian/Other Pacific Islander: Guamanian or Chamorro/Samoan
- White/Caucasian
- Black/African American
- American Indian/Alaska Native
- More than one race
- Unreported/Choose not to disclose race

Sliding fee discount: A discount that adjusts fees based on the patients' ability to pay based on their income and family/household size.

Sexual Orientation and Gender Identity (S.O.G.I):

Birth Sex: Your sex at birth. (Male or Female)

Gender Identity: How you feel about yourself as being a male/man or female/women, can be different than your birth sex.

- Transgender (male to female): Male at birth who identifies as a female
- Transgender (female to male): Female at birth who identifies as a male

Sexual Orientation: How people describe their personal (emotional and physical) attraction to others.

- Heterosexual: Men who are attracted to women and women who are attracted to men
- Gay: Someone who is attracted to the same gender as themselves.
- Lesbian: Women who are attracted to other women
- Bisexual: Someone who is attracted to women and men

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Financial Information Form

The purpose of collecting the following information is to determine your federal poverty level. Your federal poverty level will determine if you may be eligible to any programs or benefits. These programs consist of Opsam Health's financial assistance programs, Medicaid/CHIP coverage and savings in the marketplace for health insurance.

Patient Information

Full Name:	**Date of Birth:**

Part A: Household Income and Size Information

A **household** consists of all the people who occupy a house or apartment. Adult children living at home who are no longer dependent are considered a separate household. Roommates who share living arrangements but are not tied to one another through marriage, children or similar relationships are considered separate households. Those living with a friend or relative during a time of need are also considered a separate household.

Income includes: any earnings, unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources. Noncash benefits (such as food stamps and housing subsidies) do not count.

Please complete the following information:

Total number of Household Members: _____

Total Monthly Household Income: $_____

☐ **I do not want to apply for financial assistance.**

☐ **I would like to apply for financial assistance**. (Complete Sliding Fee Discount Application)

Please Read and Sign

I certify that the information provided in this application is true and accurate to the best of my knowledge. I understand that this information can be used to determine my Poverty Level. I authorize Opsam Health to use this information provided.

Patient Signature: _____ **Date:** _____

Office Use Only

☐ RFI Staff initials: _____ ☐ RSFDP Staff initials: _____

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Sliding Fee Discount Application

Household Information

Please list everyone living in your home (including yourself). Do not include adult children living at home who are no longer dependent, roommates who share living arrangements but are not tied to one another through marriage, children or similar relationships and those friends or relative living with you during a time of need.

First and Last Name	Age	Relationship	Monthly Income
Self			

For this application to be complete please provide proof of income.

Proof of income can be any of the following:

- Current paycheck
- Documentation of Benefits (unemployment, social security, retirement, military, etc.)
- Current year filed Federal Tax Returns
- Self-Attestation

Please Read and Sign

I understand that I am personally responsible for all health center charges until such time as I have supplied the necessary documentation to support my application. I understand that I will be charged the full fee for my visit if I do not provide the documentation of income within 14 days of the signed date on this application. I understand that I am required to notify Opsam Health if my income level changes or if I become insured. If there are changes, I will be reassessed for the sliding fee scale.

Patient Signature: _____ **Date:** _____

Office Use Only

Slide Assigned: ☐ A ☐ B ☐ C ☐ D ☐ E ☐ F

Income Provided and Verified: ☐ Yes ☐ No Staff Initial: _____

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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:** _____

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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

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

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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:** _____

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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.

- 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

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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

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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

PATIENT RIGHTS AND RESPONSIBILITIES

AS A PATIENT, YOU HAVE THE RIGHT:

1. To receive consideration care in a manner that respects individual cultural, spiritual, and social values.
2. To receive care regardless of race, age, sex, religion, national origin, handicap, cultural or educational background, economic or health status.
3. To know the names and qualifications pf physicians and health care
4. To know in advance, the time and location of your appointment as well as the person providing the care.
5. To privacy within the limits specified by law.
6. To have your health care provider send protected health information to a third party and/or have anyone of your choice involved in your medical treatment.
7. To confidential treatment of communications and records pertaining to your health care. You also have the right to access your medical records as permitted by law.
8. To be able to communicate with your Primary Physician regarding your medical needs.
9. To expect that efforts will be made to provide continuous, coordinated, and appropriate care.
10. To be informed of the nature of our illness and treatment options, including benefits, risks, alternatives, and costs.
11. To actively participate indecisions regarding you on health and treatment options.
12. To be advised if a physician proposes to engage in research or experimental treatment that affects your health care and to refuse to participate in such research projects.
13. To refuse treatment or leave the health center, even against the advice of physicians providing you accept the responsibility and consequences of the decision.
14. To voice a complaint without discrimination and expect problems to be fairly examined and appropriately addressed.
15. To ask for assistance when you have special needs.
16. To request and receive information regarding the charges for any treatment, and to receive an explanation of any bills upon request.
17. To formulate advance directives, such as living will or power of attorney for health care, and to expect tat your advance directives will be followed when applicable.

AS A PATIENT, YOU HAVE THE RESPONSIBILITY:

1. To provide your physician or other health care provider the information needed in order to care for you.
2. To do your part to improve your own health condition by following treatment plans, instructions, and care that you have agreed upon with your physician(s).
3. To keep appointments reliably and be on time to notify the appointment desk as early as possible when unable to do so.
4. To fulfill the financial obligations for care in a timely manner.
5. To be considerate and conduct yourself in a manner that does not disrupt the services being provided or endanger the wellbeing of others.
6. To ask questions when the information provided is not clear.
7. To voice your concerns so that we may improve our services.
8. To keep OpSam Health informed of changes in address and phone number.
9. To observe health center policies and procedures, including those regarding smoking, noise, no pets, no audio or video recording in public areas, food consumption and behavior
10. To provide accurate financial information when requested for eligibility screening for special programs.

DERECHOS Y RESPONSABILBILIDADES DEL PACIENTE

COMO PACIENTE, TIENE EL DERECHO DE:

1. Solicitar y recibir atención que respete su cultura individual y sus valores espirituales y sociales.
2. Recibir atención médica sin importar su raza, edad, sexo, religión, origen, impedimentos, historial cultural o educacional, estado de salud o económico.
3. Conocer los nombres y aptitudes de los doctores y otros profesionales envueltos en su cuidado médico.
4. Saber la hora y el lugar de su cita, como también saber información de la persona que le provee el cuidado médico.
5. Privacidad dentro de los límites especificados por la ley.
6. De tener un proveedor de salud que mande su información médica protegida a un tercero y/o a alguien que usted escoja que esté involucrado en su tratamiento médico.
7. Estar seguro de que su información médica y personal se manejara en forma confidencial. También tiene el derecho a tener acceso a su expediente médico según es permitido por la ley.
8. Poder hablar con su médico primario acerca de sus necesidades médicas.
9. Esperar que se haga un esfuerzo para proporcionarle atención continua, coordinada y apropiada.
10. Ser informado de la naturaleza de su enfermedad y de las opciones de tratamiento, incluyendo beneficios y riesgos potenciales, alternativas y costos.
11. Participar completamente en las decisiones de su cuidado médico y opciones de tratamiento.
12. Ser informado sobre cualquier tratamiento de investigación o experimental propuesto que pueda considerarse para su atención, y estar de acuerdo o rehusarse a participar.
13. Rehusar tratamiento o servicios del centro, aun en contra del consejo de los doctores proveyendo que usted acepte la responsabilidad y consecuencias de su decisión.
14. Presentar una queja y recibir una respuesta rápida y cortes sobre la calidad de la atención o de los servicios.
15. Solicitar asistencia cuando tenga necesidades especiales.
16. Solicitar y recibir información sobre los cobros por cualquier tratamiento y recibir una explicación sobre su estado de cuenta cuando lo solicite.
17. Formular una instrucción anticipada, como testamento o carta de poder duradera para cuidado médico, y esperar que sus instrucciones se cumplan cuando sea requerido.

COMO PACIENTE, TIENE LA RESPONSABILIDAD DE:

1. Proporcionar información exacta y completa sobre su estado de salud.
2. Participar hasta donde le sea posible en las decisiones sobre su tratamiento médico y cumplir con el plan de tratamiento acordado.
3. Cumplir con sus citas en forma confiable y puntual o avisar al departamento de citas si no pudiera acudir.
4. Cumplir con sus obligaciones financieras en forma puntual.
5. Ser considerado con otras personas que reciben o proporcionan atención. Comportarse de una manera que no interrumpa los servicios que se proporcionan o pongan en riesgo el bienestar de los pacientes, familiares o visitantes.
6. Hacer preguntas cuando la información proporcionada no esta
7. Dejarnos saber de sus inquietudes, de manera que podamos mejorar nuestros servicios
8. Mantener al OpSam Health informado sobre cambios de domicilio y número telefónico.
9. Observar las reglas y procedimientos del centro de salud, incluyendo las que se refieren al no fumar, ruido, sin mascotas, sin grabación audiovisual, consumo de alimentos y otras
10. Proveer información financiera exacta cuando aplique para programas especiales.

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Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can access this information. Please review it carefully.

Our Commitment and Responsibilities Regarding your Health Information

We understand that your health information is private. We are committed to protecting the privacy of this information. Each time you visit Opsam Health we create a record of the services delivered. We need this information to provide you with quality care and to comply with certain legal requirements. This notice applies to all records generated by Opsam Health whether made by health care personnel or your physician.

We hold a responsibility to safeguard your health information. We must give you this Notice of Privacy Practices. Opsam must follow the terms of the current Notice of Privacy Practices.

Changes to this Notice

Opsam Health reserves the right to change this notice. We also reserve the right to make the revised notice effective for all of your health information we already have and for any health information we receive in the future. We will post a copy of this Notice of Privacy Practices at our facilities and our website at www.Opsam.org. A copy of the current notice is available at the registration area of each facility.

How We May Use and Disclose Your Health Information

The following categories describe different ways that Opsam Health uses your health information and may disclose your health information to other persons and entities. We have not listed every use or disclosure with the categories below, but all permitted uses and disclosures will fall within one of the following categories.

Treatment: We use and disclose your health information to provide, coordinate and manage your health care and related services. We may disclose health information about you to doctors, nurses, technicians, medical student interns, or other personnel who are involved in taking care of you during your visit with us.

Payment: Opsam may use and disclose your health information to bill for services provided and to obtain payment from you, an insurance company, or a third party. This may also include the

disclosure of health information to obtain prior authorization for treatment and procedures from your insurance plan.

Health Care Operations: We may use and disclose health information about you for health care operations. These activities may include quality assurance activities, administrative activities, including Opsam Health clinic financial and business planning and development, customer service activities, including investigation of complaints, post-discharge follow-up calls, client safety activities, administrative activities. We may also use your health information to contact you to remind you of your appointment.

Business Associates: Opsam Health may use or disclose your health information to an outside company that helps us in operating our health centers or providing services on our behalf. These outside companies are called "Business Associates." Business Associates are required to keep any health information received from us confidential in the same way we do. We require Business Associates to sign a contract that states they will appropriately safeguard your health care information.

Situations That Require Your Authorization or Agreement:

With verbal agreement, or in an event necessary for care continuity where it could be inferred there would be no objection, we may disclose protected health information about you to a family member, relative, or another person identified by you who is involved in your health care or payment for your health care. You also have the right to request a restriction on disclosure of your protected health information to individuals who may be involved in your health care. If you are not present to consent, are incapacitated, or in an emergency or disaster relief situation, we will defer to professional judgment when determining where disclosing limited protected health information is in your best interest under present circumstances.

Drug and Alcohol Abuse Treatment Disclosures:

We will disclose drug and alcohol treatment information about you only in accordance with the Federal Privacy Act. In general, the Federal Privacy Act requires your written authorization for such disclosures.

Situations That Do Not Require Your Authorization

State and/or Federal laws permit the following disclosures of your protected health information without obtaining verbal or written permission.

Organ and Tissue Donation:

We may release protected 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.

Research:

We may use and disclose your health information to researchers when an institutional review board has approved their research proposal and established appropriate protocols to ensure the privacy of your health information.

To Advert a Serious Threat to Health or Safety:

We may use and disclose protected health information about you, when necessary, to prevent a serious threat to your health or safety or the health and safety of another person or the public. These disclosures would be made only to those in authority to protect the health, safety, and welfare of our communities.

Public Health Activities:

Opsam Health may disclose protected health information about you for public health activities. These generally include the following:

- To prevent or control disease, injury or disability
- To report birth and death
- To report child and adult abuse or neglect
- To report adverse events or product defects or recalls
- To notify patients who may have been exposed to an illness, disease, or may be at risk for contracting or spreading an infectious disease

Health Oversight Activities:

We may disclose protected health information about you to health oversight agencies for activities authorized by law. These activities include audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor health care systems, government programs and compliance with civil rights laws.

Lawsuits and Disputes:

If you are involved in a lawsuit or a dispute, we may disclose protected health information about you in response to a court or administrative order. We may disclose health information about you in response to a subpoena, discovery request or other lawful process by someone else involved in the dispute.

Law Enforcement Activities:

We may disclose protected health information if asked to do so by law enforcement officials for the following reasons:

- In response to a court order, subpoena, warrant summons or similar process

- To identify or locate a suspect, fugitive, material witness or missing person
- To release information about a death believed to be the result of criminal conduct
- Criminal conduct at our facility
- Mandated reporting of a crime, location of the crime or victims, or the identity, description or location of the person who may have committed the crime

Military and Veterans:

If you are a member of the armed forces, we may disclose your protected health information as required by military command authorities.

Coroners, Medical Examiners and Mortuaries:

We may disclose health information to a coroner or medical examiner. This may be necessary to identify a deceased person to determine the cause of death of a person.

National Security and Intelligence Activities:

We may disclose protected health information about you to authorized federal officials for intelligence and/or counterintelligence and other national security activities authorized by law.

Inmates:

If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose protected health information about you to the correctional institution or a law enforcement official.

Workers' Compensation

We may disclose protected health information to comply with the State's Workers' Compensation Law or similar programs if you have a work related injury.

Personal Rights Regarding Your Protected Health Information:

Please contact our Compliance Department for information or instructions on exercising any of the following rights. Please contact Opsam Compliance at (209) 683-5057, by email at compliance@opsam.org or by writing to Compliance Department Opsam Health, 1428 Highland Avenue National City, CA 91950

You have the right to:

- Request a copy of this notice. You may request a copy by calling (209) 683-5057 or by asking at the registration desk at any of our clinics.
- You have the right to inspect, copy or request electronic health data from your medical record that may have been used to make decisions about your care, subject to certain exceptions. There may be a nominal fee for processing these requests. Whether you

want to review, receive a copy or electronic health record information, you must make the request in writing. You may also request access to our patient portal to assist with access to your information. We may also deny access to certain information on the portal. If we do deny access, we will give the reason in writing. We will also explain how you may appeal the decision.

- Request an amendment to your health record if you feel the information is incorrect or incomplete. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. We may deny your request if the information was not created by our facility, is not part of the information which you would be permitted to inspect and copy, and if the information is accurate and complete. If Opsam denies your request to amend, we will send you a written notice of the denial, stating the basis for the denial and instructions offering you the opportunity to provide a written statement disagreeing with the denial.
- Obtain an accounting of disclosures of your health information. The accounting will provide a list of disclosures for purposes other than treatment, payment, and health care operations, those excluded by law or those you authorized.
- Request communication of your health information by alternative means or locations.
- Request restriction on certain uses and disclosures. You must request the restriction in writing, addressed to our Compliance Department. We are not required to agree to any restrictions you request. If we do agree, we will honor your request unless the restricted protected health information is needed to provide you with emergency treatment.
- Breach: Affected individuals have the right to be notified of a breach of their health care information.
- To complain about this notice or how we manage your health information. You may file a complaint with Opsam or with the Secretary of the Department of Health and Human Services. To file a complaint with us, please contact our Privacy Officer at 1428 Highland Avenue, National City CA 91950 or online at:

  https://opsam.my.salesforce-sites.com/RadEx__IR_Management

FORM 3-1

Advance Health Care Directive

NOTE: This form should include taglines as required by the Affordable Care Act. *(See www.calhospital.org/taglines, for detailed information.)*

Explanation

You have the right to give instructions about your own health care. You also have the right to name someone else to make health care decisions for you. This forms lets you do either or both of these things. If you use this form, you may complete or modify all or any part of it. You are free to use a different form.

Instructions

Part 1 of this form lets you name another person as "agent" to make health care decisions for you if you become incapable of making your own decisions, or if you want someone else to make those decisions for you now even though you are still capable. You may also name a different person to act for you if your first choice is not willing, able, or reasonably available to make decisions for you.

Unless you state otherwise in this form, your agent will have the right to:

1. Consent or refuse consent to any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect a physical or mental condition.
2. Select or discharge health care providers and institutions.
3. Approve or disapprove diagnostic tests, surgical procedures, and programs of medication.
4. Direct the provision, withholding, or withdrawal of artificial nutrition and hydration and all other forms of health care, including cardiopulmonary resuscitation.
5. Donate your organs, tissues, and parts; authorize an autopsy, and direct disposition of remains.

However, your agent will not be able to commit you to a mental health facility, or consent to convulsive treatment, psychosurgery, sterilization or abortion for you.

Part 2 of this form lets you give specific instructions about any aspect of your health care, whether or not you appoint an agent. Choices are provided for you to express your wishes regarding the provision, withholding, or withdrawal of treatment to keep you alive, as well as the provision of pain relief. You also can add to the choices you have made or write down any additional wishes. If you are satisfied to allow your agent to determine what is best for you in making end-of-life decisions, you need not fill out Part 2 of this form.

Give a copy of the signed and completed form to your physician, to any other health care providers you may have, to any health care institution at which you are receiving care, and to any health care agents you have named. You should talk to the person you have named as agent to make sure that he or she understands your wishes and is willing to take the responsibility.

You have the right to revoke this advance health care directive or replace this form at any time.

Name of Patient: _____

Date of Birth: _____

Part 1 — Power of Attorney for Health Care

Your agent may not be an operator or employee of a community care facility or a residential care facility where you are receiving care, or your supervising health care provider or an employee of the health care institution where you are receiving care, unless your agent is related to you or is a coworker.

Designation of Agent:

I designate the following person as my agent to make health care decisions for me:

Name of person you choose as agent: _____

Address: _____

_____

Telephone: _____
(home phone) *(work phone)* *(cell)*

OPTIONAL: If I revoke my agent's authority or if my agent is not willing, able, or reasonably available to make a health care decision for me, I designate as my alternate agent:

Name of person you choose as alternate agent: _____

Address: _____

_____

Telephone: _____
(home phone) *(work phone)* *(cell)*

Agent's Authority:

My agent is authorized to make all health care decisions for me, including decisions to provide, withhold, or withdraw artificial nutrition and hydration and all other forms of health care to keep me alive, except as I state here:

_____

_____

_____

(Add additional sheets if needed.)

When Agent's Authority Becomes Effective:

My agent's authority becomes effective when my primary physician determines that I am unable to make my own health care decisions. _____

(Initial here)

OR

My agent's authority to make health care decisions for me takes effect immediately. _____

(Initial here)

Agent's Obligation:

My agent must make health care decisions for me in accordance with this power of attorney for health care, any instructions I give in Part 2 of this form, and my other wishes to the extent known to my agent. To the extent my wishes are unknown, my agent shall make health care decisions for me in accordance with what my agent determines to be in my best interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent.

Agent's Postdeath Authority:

My agent is authorized to donate my organs, tissues, and parts, authorize an autopsy and direct disposition of my remains, except as I state here or in Part 3 of this form:

_____

_____

_____

(Add additional sheets if needed.)

Nomination of Conservator:

If a conservator of my person needs to be appointed for me by a court, I nominate the agent designated in this form. If that agent is not willing, able or reasonably available to act as conservator, I nominate the alternate agent whom I have named.

Part 2 — Instructions for Health Care

If you fill out this part of the form, you may strike any wording you do not want.

End-of-Life Decisions:

I direct that my health care providers and others involved in my care provide, withhold, or withdraw treatment in accordance with the choice I have marked below:

Choice Not To Prolong Life:

I do not want my life to be prolonged if (1) I have an incurable and irreversible condition that will result in my death within a relatively short time, (2) I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness, or (3) the likely risks and burdens of treatment would outweigh the expected benefits. _____

(Initial here)

OR

Choice To Prolong Life:

I want my life to be prolonged as long as possible within the limits of generally accepted health care standards. _____

(Initial here)

Relief From Pain:

Except as I state in the following space, I direct that treatment for alleviation of pain or discomfort be provided at all times, even if it hastens my death:

_____

_____

(Add additional sheets if needed.)

Other Wishes:

(If you do not agree with any of the optional choices above and wish to write your own, or if you wish to add to the instructions you have given above, you may do so here.) I direct that:

_____

_____

_____

_____

(Add additional sheets if needed.)

Part 3 — Donation of Organs, Tissues, and Parts at Death *(Optional)*

Upon my death:

I give my organs, tissues, and parts. _____
(Initial here to indicate yes)

By initialing this line, and notwithstanding my choice in Part 2 of this form, I authorize my agent to consent to any temporary medical procedure necessary solely to evaluate and/or maintain my organs, tissues, and/or parts for purposes of donation.

OR

I do *not* authorize the donation of any organs, tissues or parts. _____
(Initial here)

OR

I give the following organs, tissues, or parts only: _____

_____

_____
(Initial here)

My donation is for the following purposes (strike any of the following you do not want):

Transplant _____ *(Initial here)*
Research _____ *(Initial here)*
Therapy _____ *(Initial here)*
Education _____ *(Initial here)*

If you want to restrict your donation of an organ, tissue, or part in some way, please state your restriction on the following lines: _____

_____

I understand that tissue banks work with both nonprofit and for-profit tissue processors and distributors. It is possible that donated skin may be used for cosmetic or reconstructive surgery purposes. It is possible that donated tissue may be used for transplants outside of the United States.

1. My donated skin may be used for cosmetic surgery purposes.
   Yes _____ *(Initial here)* No _____ *(Initial here)*
2. My donated tissue may be used for applications outside of the United States.
   Yes _____ *(Initial here)* No _____ *(Initial here)*
3. My donated tissue may be used by for-profit tissue processors and distributors.
   Yes _____ *(Initial here)* No _____ *(Initial here)*

If I leave Part 3 blank, it is not a refusal to make a donation. My state-authorized donor registration should be followed, or, if none, my agent may make a donation upon my death. If no agent is named above, I acknowledge that California law permits an authorized individual to make such a decision on my behalf. (To state any limitation, preference, or instruction regarding donation, please use the lines above or on page 3 of this form.)

Part 4 — Primary Physician *(Optional)*

I designate the following physician as my primary physician:

Name of Physician: _____

Telephone: _____

Address: _____

_____

OPTIONAL: If the physician I have designated above is not willing, able, or reasonably available to act as my primary physician, I designate the following physician as my primary physician:

Name of Physician: _____

Telephone: _____

Address: _____

_____

Part 5 — Signature

The form must be signed by you and by two qualified witnesses, or acknowledged before a notary public.

Signature:

Sign and date the form here:

Date: _____ Time: _____ AM / PM

Signature: _____
(patient)

Print name: _____
(patient)

Address: _____

_____

Statement of Witnesses:

I declare under penalty of perjury under the laws of California (1) that the individual who signed or acknowledged this advance health care directive is personally known to me, or that the individual's identity was proven to me by convincing evidence, (2) that the individual signed or acknowledged this advance directive in my presence, (3) that the individual appears to be of sound mind and under no duress, fraud, or undue influence, (4) that I am not a person appointed as agent by this advance directive, and (5) that I am not the individual's health care provider, an employee of the individual's health care provider, the operator of a community care facility, an employee of an operator of a community care facility, the operator of a residential care facility for the elderly, nor an employee of an operator of a residential care facility for the elderly.

First Witness

Name: _____ Telephone: _____

Address: _____

_____

Date: _____ Time: _____ AM / PM

Signature: _____
(witness)

Print name: _____
(witness)

Second Witness

Name: _____ Telephone: _____

Address: _____

_____

Date: _____ Time: _____ AM / PM

Signature: _____
(witness)

Print name: _____
(witness)

Additional Statement of Witnesses:

At least one of the above witnesses must also sign the following declaration:

I further declare under penalty of perjury under the laws of California that I am not related to the individual executing this advance health care directive by blood, marriage, or adoption, and to the best of my knowledge, I am not entitled to any part of the individual's estate upon his or her death under a will now existing or by operation of law.

Date: _____ Time: _____ AM / PM

Signature: _____
(witness)

Print name: _____
(witness)

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of the document.

YOU MAY USE THIS CERTIFICATE OF ACKNOWLEDGMENT BEFORE A NOTARY PUBLIC INSTEAD OF THE STATEMENT OF WITNESSES.

State of California)

County of _____)

)

On *(date)*_____ before me, *(name and title of the officer)* _____ _____ personally appeared *(name(s) of signer(s))* _____, who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

Signature: _____ [Seal]
(notary)

Part 6 — Special Witness Requirement

If you are a patient in a skilled nursing facility, the patient advocate or ombudsman must sign the following statement:

Statement of Patient Advocate or Ombudsman

I declare under penalty of perjury under the laws of California that I am a patient advocate or ombudsman as designated by the State Department of Aging and that I am serving as a witness as required by Section 4675 of the Probate Code.

Date: _____ Time: _____ AM / PM

Signature: _____
(patient advocate or ombudsman)

Print name: _____
(patient advocate or ombudsman)

Address: _____

Civil Code Section 1189; Health and Safety Code Section 7158.3; Probate Code Section 4701

Authorization to Use or Disclose Protected Health Information

I hereby authorize use or disclosure of the named individual's health information as described below

Patient/Client

Last Name:_____ **First Name:**_____ **Middle Initial:**_____ **Date:**_____

Address:_____ **City:**_____ **State:**_____ **Zip Code:**_____

Phone number:_____ **SSN:**_____ **DOB:**_____

THE FOLLOWING INDIVIDUAL OR ORGANIZATION IS AUTHORIZED TO MAKE THE DISCLOSURE

Last Name or Entity:_____ **First Name:**_____ **Middle Initial:**_____

Address:_____ **City:**_____ **State:**_____ **Zip Code:**_____

Phone Number:_____ **Date:**_____

THIS INFORMATION MAY BE DISCLOSED TO AND USED BY THE FOLLOWING INDIVIDUAL OR ORGANIZATION

Last Name or Entity:_____ **First Name:**_____ **Middle Initial:**_____

Address:_____ **City:**_____ **State:**_____ **Zip Code:**_____

Phone Number:_____ **Fax Number:**_____ **Date:** _____

Treatment Dates:_____

Purpose of Request: ☐**At the request of individual** ☐**Other:**_____

THE FOLLOWING INFORMATION IS TO BE DISCLOSED: (PLEASE CHECK)

Pertinent Information (This is what most physicians need):

☐Clinic problem list, immunizations, Progress notes, Labs, Radiology, medication list

☐Hospital discharged summary and specialists' consultations for hospitalization from _____

☐ER Physician's dictated notes and diagnostic imaging reports & specialists' consultations from _____

☐All prenatal records

☐Other – please be specific _____

Authorized to release Statutorily Protected Information:

☐Mental Health Treatment Information

☐Psychiatric Progress Notes

☐Therapy Notes

☐Labs

☐HIV/AIDS Test Results

☐Alcohol/Drug Treatment Information

Sensitive Information: I understand that the information in my record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or infection with the Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol and drug abuse.

Right to Revoke: I understand that I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing. I understand that the revocation will not apply to information that has already been released based on this authorization.

Expiration: Unless otherwise revoked, this authorization will expire on the following date, event, or condition. If I do not specify an expiration date, event or condition, this authorization will expire in one (1) calendar year from the date it was signed.

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

Other Rights: I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to assure treatment. However, if this authorization is needed for participation in a research study, my enrollment in the research study may be denied.

I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in 45 Code of Federal Regulations section164.524.

I have the right to receive a copy of this authorization. I would like a copy of this authorization: ☐Yes ☐No

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Signature of Individual or Legal Representative

Signature:_____ **Date:**_____

If Signed by Legal Representative, Relationship of Individual: _____

For Patients requesting medical records, there will be a fee of $20.00 per request and 25 cents for each additional page.