Primary Care West, P.C.

1255 Wallace Rd. N.W.
Salem, OR 97304

(503) 362-1314

Dear Primary Care West Patient,

We would like to take the opportunity to welcome you to our clinic and to thank you for choosing us as your health care provider.

Our clinic hours are Monday through Thursday from 7:30 a.m. to 5:00 p.m. and Friday from 8:30 a.m. to 5:00 p.m. Our phones are off from 12:00 p.m. to 1:00 p.m. for lunch. In the event of an emergency during this time, our answering service will put your call through. Our answering service is available 24/7 and can be reached by dialing our clinic at 503 362-1314. We always save appointments in our schedule for the care you need right away.

Please arrive 10-15 minutes early for your appointment. Doing so will give you plenty of time to check- in and have your vitals (height, weight, blood pressure) taken before your appointment time. It also will help you get as much time with your practitioner as possible**. Registration Paperwork must be completed by the start of your appointment time. If it is not completed you may be asked to reschedule.**

Let your doctor/nurse practitioner know if you need refills on any of your medications when you are here for your appointment. We do not authorize medication refills over the phone or fax. Your practitioner prefers to direct their time to patient care. You will be given enough refills to last until your practitioner needs to see you again. Generally, if you need a refill you will be asked to come to the clinic to review your medical condition.

In consideration of our patients with migraine headaches, allergies, asthma, or other respiratory problems, we ask that you do not wear perfume, cologne, or scented lotion to our clinic.

We would like to introduce you to the team members responsible for coordinating your care:

Connie, Rachel, and Dawn, our Certified Medical Assistants, will conduct your pre-visit medication reconciliation, take your vitals, confirm the purpose of your visit and order any procedures you may need obtaining prior authorizations when needed. Questions you have for your provider, including test results, will be monitored and responded to by them after consult with your provider as necessary. Trina and Elaina, our Front Desk Staff, will coordinate your referrals and respond to any medical record requests. Jonni, our Billing Manager, will help you with any concerns or questions you may have about your account balance.

Any employee who receives a grievance from a patient/family member will immediately attempt to resolve the grievance within that employee's role and authority. If the grievance cannot be immediately resolved, the employee shall notify the manager of the clinic. The manager will resolve the grievance or take steps to continue the resolution process with the knowledge and agreement of the patient/family making the grievance.

Please do not hesitate to ask any of us any questions you might have.

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PATIENT REGISTRATION

PATIENT INFORMATION

Name ________________________________Mailing Address ________________________________City__________ ST _____ZIP________

Address (if different from mailing) ____City__________________ST________ZIP________

Email address____________________________________ Employer_____________________________________

Phone Numbers: Cell_________________________Home_________________________Work_____________________________

Birth Date_____________ SS#_____________________ Biological Sex________ Pronoun__________ Relationship Status_________________

Spouse/Partner Name _______________________Birth Date ______________SS#____________________________

Spouse/Partner Employer________________________________Phone#____________________________________

INSURANCE INFORMATION

**** COPAY DUE AT TIME OF SERVICE****

Primary Insurance________________________________Gr#______________________ID#_______________________________________
(Include Alpha Characters)

Subscriber_______________________________________Birthday________________SS#_____________________________

Secondary Insurance________________________________Gr#______________________ID#____________________________________

Subscriber_______________________________________Birthday________________SS#_____________________________

EMERGENCY INFORMATION

Relative (other than spouse/partner) ______________________________Phone#___________________Relation___________________

Non-Relative____ Phone#____________________ Relation___________________

PLEASE READ

I, THE UNDERSIGNED, do hereby authorize Laslo Kolta, MD, Katie Tihanyi, MD, Serena Caldwell, FNP and/or Susi Cunningham, FNP to release any information to my insurance company as is needed to process my claim.
I hereby assign to Primary Care West, PC all monies to which I am entitled for medical expenses relative to services performed.
I understand that I am financially responsible for any and all charges not covered by this assignment.
If I have no insurance, the balance for the services rendered is my responsibility in its entirety at the TIME OF SERVICE.

Please list any **family members (under 18)** that the above information applies to other than you.

NAME__________________________DOB____________ NAME__________________________DOB___________

NAME__________________________DOB____________ NAME__________________________DOB___________

NAME__________________________DOB____________ NAME__________________________DOB___________

SIGNATURE____**DATE**________________
(Must be over 18)

Name: ________________________ Date: __________________D.O.B._____________________

Preferred Name: ___________________________ Pronoun: ______________________________

Occupation: ______________________________ Employer: ____

Ethnicity: _________________________________ Race: ____

Preferred language: _________________________ Relationship status: __________________________________

Religious affiliation: _________________________ Who primarily lives with you: ___________________________

Preferred Pharmacy: __________________________

Medications with Dosages:

____ ____
____ ____
____ ____
____ ____
____ ____

Known Medication Allergies:

____
____
____

Other Allergies:

____
____
____

Immunization History:

Year of last Tetanus__________________ Year of last TB test__________________ Had a shingles shot? ________________

Do you get yearly flu shots? ___________ Last pneumonia shot________________

Have you ever had a Hep A or Hep B shot? (Please circle which one)________________________

Past Medical History:

Operations/Surgeries

	Type	Surgeon	Year	City
1.				
2.				
3.				
4.				

Hospitalizations:

	Reasons	Year	Hospital
1.			
2.			
3.			=

Serious Illness or Injury:

Approx. year

1. ____
2. ____
3. ____
4. ____

Name: ________________________ Date: __________________D.O.B._____________________

Specialists

Name | Date last seen | Current?

1. ____
2. ____
3. ____
4. ____
5. ____

Additional comments that you feel may be helpful to the doctor:

1. ____
2. ____
3. ____

Smoking/Vaping

☐ Current ☐ Past ☐ Never

Cigarettes/e-cigs a day _________

Age Started Smoking __________

Years smoked _________

Interest in quitting? _________

Caffeine: ☐Yes ☐No

Type ____________________

Per week ____________________

Alcohol: ☐Yes ☐No

How many drinks per week__________________________

Type: _______________________

Exercise: ☐Yes ☐No

Type ___________________

How often___________________

Calcium Intake:

Milk

Cups/day_____________

Supplements

Mg/day_____________

Social History:

Yes / no

______/______ Are you on a special diet? If yes, what kind? ________________________________

______/______ Do you have a history of an eating disorder? ________________________________

______/______ In the past year, have you been afraid of your partner/ex-partner?

______/______ Do you feel physically and emotionally safe where you currently live?

______/______ Has the lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living?

In the past year, have you or any family member you live with been unable to get any of the following when it was really needed?

☐ Food ☐ Clothing ☐ Utilities ☐ Child Care ☐ Phone ☐ Medicine/Healthcare ☐ Other____________

Have you had more than one partner in your lifetime? ____

Have you had a new partner since your last exam? ____

Do you have need for birth control now? __________________ Current method of birth control? ______________________

Name: ________________________ Date: __________________D.O.B.______________________

We ask all adult patients about substance use and mood because these factors can affect your health. Please ask your doctor if you have any questions. Your answers on this form will remain confidential.

Over the last two weeks, how often have you been bothered by any of the following problems?

1. Little interest or pleasure in doing things? ☐ Not at all ☐ Several days ☐ More than half ☐ Nearly Everyday
2. Feeling down, depressed, or hopeless? ☐ Not at all ☐ Several days ☐ More than half ☐ Nearly Everyday

How many times per year have you used a recreational drug or used a prescription medication for non-medical reasons? ☐ None ☐ 1 or more

Men: How many times in the past year have you had 5 or more drinks in a day? ☐ None ☐ 1 or more

Women: How many times in the past year have you had 4 or more drinks in a day? ☐ None ☐ 1 or more

Male Issues

pos.	neg.	
☐	☐	Infertility
☐	☐	Sexual Dysfunction
☐	☐	Decreased Libido
☐	☐	Circumcised
☐	☐	Erectile Pain
☐	☐	History of Hydrocele
☐	☐	Penile Discharge
☐	☐	Herpes Genitalia
☐	☐	Scrotal/testicular Pain
☐	☐	History of STI

Female Issues

pos.	neg.	
☐	☐	Menopausal
☐	☐	Hormone Replacement
☐	☐	Vaginal Discomfort
☐	☐	Herpes Genitalia
☐	☐	Self-Breast Exams
☐	☐	History of STI
☐	☐	History of Abnormal Paps
☐	☐	Normal Periods
☐	☐	Infertility
☐	☐	Sexual Dysfunction

Female Reproduction:

Age on onset of your very first period ______________________ First day of last period__________________________________

Number of days between periods _________________________ How many days do you flow? ___________________________

On your heaviest days, how many tampons/pads do you use? How many heavy days do you have? ____________________

Do you have bleeding between periods? ___________________ Any bleeding after sex? ________________________________

Have you had a hysterectomy? ___________________________ If yes, were your ovaries removed? ______________________

If menopausal, when was your last period? _________________ Do you wish to discuss hormones? _______________________

Have you ever had an abnormal pap? __________________ If yes, when? ___________What did it show? _______________________

Number of pregnancies_______ Number of live births__________ Number of abortions/miscarriages? ________

Name: ________________________ Date: __________________ D.O.B. _____________________

Constitutional all negative ☐

Yes	No	
☐	☐	Chills/fever/malaise
☐	☐	Decreased Activity
☐	☐	Decreased Appetite
☐	☐	Insomnia
☐	☐	Irritability
☐	☐	Night Sweats
☐	☐	Weight Gain
☐	☐	Weight Loss

Eyes/Head all negative ☐

Yes	No	
☐	☐	Snoring
☐	☐	Eye Floaters
☐	☐	Vision Loss
☐	☐	Dry/Watering Eyes
☐	☐	Headaches

Ears all negative ☐

Yes	No	
☐	☐	Excessive Wax
☐	☐	Ear Pain
☐	☐	Discharge
☐	☐	Hearing Loss
☐	☐	Fullness

Nose all negative ☐

Yes	No	
☐	☐	Nose Bleeds
☐	☐	Facial Pain
☐	☐	Drainage/Congestion

Mouth all negative ☐

Yes	No	
☐	☐	Throat Pain
☐	☐	Swallowing Issues
☐	☐	Cold Sores
☐	☐	Hoarseness

Dermatologic all negative ☐

Yes	No	
☐	☐	Acne
☐	☐	Contact Allergies
☐	☐	Excessive Sweating
☐	☐	Excessive Sun
☐	☐	Hair Loss
☐	☐	Moles/Lesions
☐	☐	Nail Changes
☐	☐	Rashes
☐	☐	Sensitivity to light
☐	☐	Pigment Changes

Respiratory all negative ☐

Yes	No	
☐	☐	Trouble breathing
☐	☐	Double Vision
☐	☐	Cough
☐	☐	Sleep Apnea
☐	☐	Wheezing

Cardiovascular all negative ☐

Yes	No	
☐	☐	Chest Pain
☐	☐	Fainting
☐	☐	Swelling
☐	☐	Irregular Heart Rate

Gastrointestinal all negative ☐

Yes	No	
☐	☐	Abdomen Pain
☐	☐	Heartburn/reflux
☐	☐	Rectal Bleeding
☐	☐	Constipation
☐	☐	Decreased Appetite
☐	☐	Gassiness
☐	☐	Diarrhea
☐	☐	Hemorrhoids
☐	☐	Nausea/Vomiting
☐	☐	Bloody Stools

Genitourinary all negative ☐

Yes	No	
☐	☐	Incontinence
☐	☐	Back Pain
☐	☐	Cloudy Urine
☐	☐	Painful/frequent urination
☐	☐	Blood in urine
☐	☐	Decreased Stream

Endocrine all negative ☐

Yes	No	
☐	☐	Voice Changes
☐	☐	Excessive Thirst
☐	☐	Hypoglycemia
☐	☐	Infertility
☐	☐	Abnormal Hair Growth
☐	☐	Unable to lose/gain weight
☐	☐	Heat/cold intolerance
☐	☐	Excessive urination
☐	☐	Excessive sweating
☐	☐	Change in sleep

Hematology all negative ☐

Yes	No	
☐	☐	Clotting Issues
☐	☐	Easy Bleeding
☐	☐	Easy Bruising

Immunology all negative ☐

Yes	No	
☐	☐	Bee sting allergy
☐	☐	Hay fever
☐	☐	Hives
☐	☐	Animals in home
☐	☐	Chemicals in workplace
☐	☐	Asthma

Primary Care West, P.C.

Name: ________________________ Date: __________________D.O.B._____________________

Musculoskeletal all negative ☐

Yes	No	
☐	☐	Muscle Weakness
☐	☐	Muscle Pain
☐	☐	Neck Stiffness/Pain
☐	☐	Bone/Joint Symptoms
☐	☐	Back Stiffness
☐	☐	Serious Back Injury
☐	☐	Lower Back Pain
☐	☐	Mid Back Pain

Neurological all negative ☐

Yes	No	
☐	☐	Numbness/Tingling
☐	☐	Coordination Issues
☐	☐	Gait Issues
☐	☐	Light Headedness
☐	☐	Weakness of arms/legs

Vascular all negative ☐

Yes	No	
☐	☐	Edema
☐	☐	Varicose Veins
☐	☐	Raynaud's
☐	☐	Poor Circulation

Psychiatric all negative ☐

Yes	No	
☐	☐	History of Depression
☐	☐	Anxiety
☐	☐	Panic Attacks
☐	☐	OCD

Please check all boxes appropriate for family members:

☐ Adopted/Unknown

Relation	Alive	Age	Arthritis	Alcohol Abuse	Cancer	Bleeding Disorder	Seizure Disorder	High Blood Pressure	Heart Disease	High Cholesterol	Diabetes	Mental Illness	Reason for Death
Self													
Mother's Mother													
Mother's Father													
Father's Mother													
Father's Father													
Father													
Mother													
Brothers													
Sisters													
Spouse													
Children													

Are you of Hispanic or Latino origin or descent?

[ ] Yes, Hispanic or Latino

[ ] No, not Hispanic or Latino

[ ] Decline to answer

What is your race?

[ ] Caucasian

[ ] Black or African American

[ ] Asian

[ ] Native Hawaiian or Other Pacific Islander

[ ] American Indian or Alaska Native

[ ] Other

[ ] Decline to answer

What is your primary language spoken at home?

[ ] English

[ ] Cantonese

[ ] Chinese

[ ] Hungarian

[ ] Vietnamese

[ ] Spanish

[ ] Other

[ ] Decline to answer

Primary Care West, PC
1255 Wallace Rd NW   Salem, OR 97304
Tel 503-362-1314 | **Fax** 503-362-5895
http://primarycarewest.com

CONSENT/AUTHORIZATION TO DISCLOSE MEDICAL RECORDS

Name____ DOB__________________________________

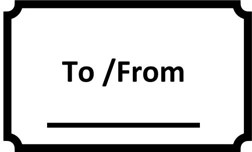
I hereby Consent and Authorize <u>Primary Care West, PC</u> to:

1. CHECK ONLY ONE

____ **Send/give** a copy of my specific health information to person or organization named below.
____ **Receive** a copy of specific health information from person or organization named below.
____ **Orally** exchange specific health information with person or organization below.

2. CONSISTING OF (check all that apply)

____ Entire Medical Record ____ Physical therapy records ____ Lab reports
____ Most recent Annual and Pap ____ Diagnostic imaging reports ____ Pathology report
____ TB information, including X-ray report if applicable ____ Immunizations
____ Other ____



To /From

Name____

Address____Telephone________________

City/State/Zip____Fax_____________________

FOR THE PURPOSE OF: (describe purpose of disclosure) ☐ Continuity of Care ☐ Transfer of Care
☐ Other____

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed if I place my **<u>INITIALS</u>** in the applicable space next to the type of information.

****** The following <u>must be initialed</u> in order for it to be included in your request.***

____ HIV/AIDS information ____ Genetic testing information
____ Drug/alcohol diagnosis, treatment, or referral information ____ Mental health information

You may revoke this authorization in writing at any time. If you revoke your authorization, the information described above may no longer be used or disclosed for the purposes described in this written authorization. The only exception is when a covered entity has taken action in reliance on the authorization or the authorization was obtained as a condition of obtaining insurance coverage. To revoke this authorization, please send a written statement to Primary Care West PC, 1255 Wallace Rd, Salem, OR 97304 and state that you are revoking this authorization.
You do not need to sign this authorization. Refusal to sign the authorization will not adversely affect your ability to receive health care services or reimbursement for services. The only circumstance when refusal to sign means you will not receive health care services is if the health care services are solely for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure.

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict redisclosure of HIV/AIDS information, mental health information, genetic testing information and drug/alcohol diagnosis, treatment or referral information. I have read this authorization and I understand it. Unless revoked, this authorization will expire in one year or until (please specify) __________.
If I fail to specify an expiration date or event, this authorization will expire one year form the date on which it was signed.

____ __________________ _____________________
Signature of individual or personal representative Date Your Telephone

Primary Care West, P.C.

1255 Wallace Rd. N.W.
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(503) 362-1314

Primary Care West, PC Appointment Policy

No Show Policy

Primary Care West is committed to providing all of our patients with exceptional care. When a patient cancels without giving enough notice, they prevent another patient from being seen who is in need of our care. We ask that you provide at least twenty-four hours' notice if you are unable to keep your scheduled appointment.

All missed appointments and/or late cancellations are tracked within the patient's medical record. A patient who has missed an appointment or calls with a late cancellation within a twelve month period will receive a letter stating our policy. If two appointments are missed within the twelve month period, a letter will be mailed and up to a $50.00 fee will be charged. After a third missed appointment within the twelve month period, there will be a fee of up to $100.00 charged and the patient may be discharged from our clinic.

We understand there may be unavoidable circumstances that may cause you to cancel. To be respectful of the medical needs of other patients, please be courteous and call 503 362-1314 to cancel your appointment.

Our answering service will relay your message if we are unavailable to take your call.

Late Arrival Policy

Patients arriving more than ten minutes late for their office or well visit appointment will be considered a no show and will be asked to reschedule for another day. Patients who have scheduled an urgent, non-life threatening appointment that needs same day evaluation will be seen as the schedule allows, or asked to go to urgent care.

NOTICE OF PRIVACY PRACTICES

Effective Date: September 23, 2013

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

PLEASE REVIEW IT CAREFULLY.

If you have any questions about this notice, please contact our

HIPAA Privacy Officer Anna Ewert at 503 362-1314

1255 Wallace Rd NW Salem, OR 97304

WHO WILL FOLLOW THIS NOTICE

This notice describes the information privacy practices followed by our employees, staff and other personnel.

YOUR HEALTH INFORMATION

This notice applies to the information and records we have about you, your health, health status, and the health care and services you receive from Primary Care West. Your health information may include information created and received by Primary Care West, may be in the form of written or electronic records or spoken words, and may include information about your health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, related billing activity and similar types of health-related information.

We are required by law to give you this notice. It will tell you about the ways in which we may use and disclose health information about you and describes your rights and our obligations regarding the use and disclosure of that information.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose health information for the following purposes:

- **For Treatment.** We may use health information about you to provide you with medical treatment or services. We may disclose health information about you to doctors, nurses, technicians, staff or other personnel who are involved in taking care of you and your health.

  For example, your doctor may be treating you for a heart condition and may need to

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know if you have other health problems that could complicate your treatment. The doctor may use your medical history to decide what treatment is best for you. The doctor may also tell another doctor about your condition so that doctor can help determine the most appropriate care for you.

Different personnel in our organization may share information about you and disclose information to people who do not work for Primary Care West in order to coordinate your care, such as phoning in prescriptions to your pharmacy, scheduling lab work and ordering x-rays. Family members and other health care providers may be part of your medical care outside this office and may require information about you that we have. We will request your permission before sharing health information with your family or friends unless you are unable to give permission to such disclosures due to your health condition.

For payment. We may use and disclose health information about you so that the treatment and services you receive at Primary Care West 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 a service you received here so your health plan will pay us or reimburse you for the service. 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 pay for the treatment.

For Health Care Operations. We may use and disclose health information about you in order to run Primary Care West and make sure that you and our other patients receive quality care.

For example, we may use your health information to evaluate the performance of our staff in caring for you. We may also use health information about all or many of our patients to help us decide what additional services we should offer, how we can become more efficient, or whether certain new treatments are effective.

We may also disclose your health information to health plans that provide you insurance coverage and other health care providers that care for you. Our disclosures of your health information to plans and other providers may be for the purpose of helping these plans and providers provide or improve care, reduce cost, coordinate and manage health care and services, train staff and comply with the law.

SPECIAL SITUATIONS

We may use or disclose health information about you for the following purposes, subject to all applicable legal requirements and limitations:

- **To Avert a Serious Threat to Health or Safety.** We may use and disclose health

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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.

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

- **Research.** We may use and disclose health information about you for research projects that are subject to a special approval process. We will ask you for your permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care at the office.

- **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 such donation and transplantation.

- **Military, Veterans, National Security and Intelligence.** If you are or were a member of the armed forces, or part of the national security or intelligence communities, we may be required by military command or other government authorities to release health information about you. We may also release information about foreign military personnel to the appropriate foreign military authority.

- **Workers' Compensation.** We may release health information about you 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 reasons in order to prevent or control disease, injury or disability; or report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products.

- **Health Oversight Activities.** We may disclose health information to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs, and compliance with civil rights laws.

- **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. Subject to all applicable legal requirements, we may also disclose health information about you in response to a subpoena.

- **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, subject to all applicable legal requirements.

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- **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.

- **Information Not Personally Identifiable.** We may use or disclose health information about you in a way that does not personally identify you or reveal who you are.

- **Family and Friends.** We may disclose health information about you to your family members or friends if we obtain your verbal agreement to do so or if we give you an opportunity to object to such a disclosure and you do not raise an objection. We may also disclose health information to your family or friends if we can infer from the circumstances, based on our professional judgment that you would not object. For example, we may assume you agree to our disclosure of your personal health information to your spouse when you bring your spouse with you into the exam room or the hospital during treatment or while treatment is discussed.

  In situations where you are not capable of giving consent (because you are not present or due to your incapacity or medical emergency), we may, using our professional judgment, determine that a disclosure to your family member or friend is in your best interest. In that situation, we will disclose only health information relevant to the person's involvement in your care. For example, we may inform the person who accompanied you to the emergency room that you suffered a heart attack and provide updates on your progress and prognosis. We may also use our professional judgment and experience to make reasonable inferences that it is in your best interest to allow another person to act on your behalf to pick up, for example, filled prescriptions, medical supplies, or X-rays.

OTHER USES AND DISCLOSURES OF HEALTH INFORMATION

We will not use or disclose your health information for any purpose other than those identified in the previous sections without your specific, written *Authorization*. If you give us *Authorization* to use or disclose health information about you, you may revoke that *Authorization*, in writing, at any time. If you revoke your *Authorization*, we will no longer use or disclose information about you for the reasons covered by your written *Authorization*, but we cannot take back any uses or disclosures already made with your permission.

In some instances, we may need specific, written authorization from you in order to disclose certain types of specially-protected information such as substance abuse information for purposes such as treatment, payment and healthcare operations.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

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

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- **<u>Right to Inspect and Copy</u>.** You have the right to inspect and copy your health information, such as medical and billing records, that we keep and use to make decisions about your care. You must submit a written request to our HIPAA Privacy Officer Anna Ewert in order to inspect and/or copy records of your health information. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other associated supplies. 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. A modified request may include requesting a summary of your medical record.

  If you request to view a copy of your health information, we will not charge you for inspecting your health information. If you wish to inspect your health information, please submit your request in writing to our HIPAA Privacy Officer Anna Ewert. You have the right to request a copy of your health information in electronic form if we store your health information electronically.

  We may deny your request to inspect and/or copy your record or parts of your record in certain limited circumstances. If you are denied copies of or access to, health information that we keep about you, you may ask that our denial be reviewed. If the law gives you a right to have our denial reviewed, we will select a licensed health care professional to review your request and our denial. The person conducting the review will not be the person who denied your request, and we will comply with the outcome of the review.

- **<u>Right to Amend</u>.** If you believe health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment as long as the information is kept by Primary Care West.

  To request an amendment, complete and submit a MEDICAL RECORD AMENDMENT/CORRECTION FORM to our HIPAA Privacy Officer Anna Ewert.

  We may deny your request for an amendment if your request is not **in writing** or does not include a reason to support the request. In addition, we may deny or partially deny your request if you ask us to amend information that:

  - We did not create, unless the person or entity that created the information is no longer available to make the amendment

  - Is not part of the health information that we keep

  - You would not be permitted to inspect and copy

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- Is accurate and complete

If we deny or partially deny your request for amendment, you have the right to submit a rebuttal and request the rebuttal be made a part of your medical record. Your rebuttal needs to be two pages in length or less and we have the right to file a rebuttal responding to yours in your medical record. You also have the right to request that all documents associated with the amendment request (including rebuttal) be transmitted to any other party any time that portion of the medical record is disclosed.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you for purposes other than treatment, payment, health care operations, when specifically authorized by you and a limited number of special circumstances involving national security, correctional institutions and law enforcement.

To obtain this list, you must submit your request **in writing** to our HIPAA Privacy Officer Anna Ewert. It must state a time period, which may not be longer than six years. 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 health information we disclose about you to someone who is involved in your care or the payment for it, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery 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 or we are required by law to use or disclose the information.

We are required to agree to your request if you pay for treatment, services, supplies and prescriptions "out of pocket" and you request the information not be communicated to your health plan for payment or health care operations purposes. There may be instances where we are required to release this information if required by law.

To request restrictions, you may complete and submit the REQUEST FOR RESTRICTION ON USE/DISCLOSURE OF MEDICAL INFORMATION to our HIPAA Privacy Officer Anna Ewert.

- **Right to Request Confidential Communications.** You have the right to request that we

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communicate with you about medical 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 may complete and submit the REQUEST FOR RESTRICTION ON USE/DISCLOSURE OF MEDICAL INFORMATION AND/OR CONFIDENTIAL COMMUNICATION to our HIPAA Privacy Officer Anna Ewert . 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 it electronically, you are still entitled to a paper copy. [*You may also find a copy of this Notice on our web site.]*

  To obtain such a copy, contact our HIPAA Privacy Officer Anna Ewert

CHANGES TO THIS NOTICE

We reserve the right to change this notice, and to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post the current notice at our location(s) with its

effective date in the top right hand corner. You are entitled to a copy of the notice currently in effect.

We will inform you of any significant changes to this Notice. This may be through our newsletter, a sign prominently posted at our location(s), a notice posted on our web site or other means of communication.

BREACH OF HEALTH INFORMATION

We will inform you if there is a breach of your unsecured health information.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services.

To file a complaint with Primary Care West, contact Anna Ewert, Practice Manager *at 503 362-1314.* ***You will not be penalized for filing a complaint.***

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Primary Care West, P.C.

1255 Wallace Rd. N.W.
Salem, OR 97304

(503) 362-1314

Serena Caldwell, FNP
Family Nurse Practitioner

Susi Cunningham, FNP
Family Nurse Practitioner

Katie Tihanyi, MD
Family Medicine

ACKNOWLEDGMENT AND CONSENT

I understand that Primary Care West, P.C. will use and disclose **health information** about me.

I understand that my **health information** may include information both created and received by the practice, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that This Practice may **use and disclose** my health information in order to:

- make decisions about and plan for my care and treatment;
- refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment;
- determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care; and
- Perform various office, administrative and business functions that support my physician's efforts to provide me with, arrange, and be reimbursed for, quality cost-effective health care.

I also understand that I have the right to receive and review a written description of how this practice will handle health information about me. This written description is known as a **Notice of Privacy Practices** and describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of This Practice, and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy or a summary of the most current version of This Practice's Notice of Privacy Practices in effect will be posted in waiting/reception area.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that This Practice is not required by law to agree to such requests.

By signing below, I agree that I have reviewed and understand the information above and that <u>I have received</u> a copy of the Notice of Privacy Practices.

Printed Name: ____

Signature: ____ Date: __________________
(Patient or Patient Representative)

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Primary Care West, P.C.

1255 Wallace Rd. N.W.
Salem, OR 97304

(503) 362-1314

Notice of Your Right to Decline Participation in Future Anonymous or Coded Genetic Research

The State of Oregon has laws to protect the genetic privacy of individuals. These laws give you the right to decline to have your health information or biological samples used for research. A biological sample may include a blood sample, urine sample, or other materials collected from your body. You can decide whether to allow your health information or biological samples to be available for genetic research. Your decision will not affect the care you receive from your health care provider or health insurance coverage.

Research is important because it gives us valuable information on how to improve health, such as ways to prevent or improve treatment for heart disease, diabetes, and cancer. Under Oregon law, a special team reviews all genetic research before it begins. This team makes sure that the benefits of the research are greater than any risks to participants.

In anonymous research, personal information that could be used to identify you, like you name or medical record number, cannot be linked to your health information or biological sample. In coded research, personal information that could be used to identify you is kept separate from your health information or biological sample so it would be very difficult for someone to link your personal information to your health information or biological sample. Your identity is protected in both types of research.

If you want to allow your health information and biological sample to be available for anonymous or coded genetic research, **you don't have to do anything.** If you make this choice, your health information or biological sample may be used for anonymous or coded research without further notice to you.

If you want to decline to have you health information and biological sample available for anonymous or coded genetic research, you must **tell your health care provider** by:

- Completing this form and giving it to your health care provider
- Completing this form and mailing it to Primary Care West, P.C., 1255 Wallace Rd. NW, Salem, OR 97304.
- You may access the document through a link on the front page of the OAHHS website under "Legal and Regulatory, Genetic Research Notice and Opt out Regulations and Guidelines" at www.oahhs.org.

Your decision is effective on the date your health care provider receives this form.

If you have any questions or concerns about this notice, please contact Anna Ewert at 503-362-1314.

No matter what you decide now, you can always change your mind later. If you change your mind, inform your health care provider of your decision in writing. If you change your mind, the new decision will apply only to health information or biological samples collected after your health care provider receives written notice of your new decision.

Primary Care West, P.C.

1255 Wallace Rd. N.W.
Salem, OR 97304

(503) 362-1314

☐ I decline to have my health information and biological samples available for anonymous or coded genetic research.

____

Printed Name and Birth date

Please list other family members and their birth dates under the age of sixteen that you would like to include in this Opt-out notice.

____

Printed Name and Birth date

____

Printed Name and Birth date

____

Printed Name and Birth date

____

Printed Name and Birth date

Primary Care West, P.C.

1255 Wallace Rd. N.W.
Salem, OR 97304

(503) 362-1314

Immunization Policy

Our clinic follows the standard immunization schedule endorsed by the Centers for Disease Control (CDC), American Academy of Pediatrics Family Practice (AAP) and American Counsel on Immunizations Practices (ACIP). Immunizations are the most effective way to safeguard children's health from serious and fatal infectious diseases.

While we recognize parents have an important role in healthcare decisions in regard to their children, including immunizations, we are also responsible for the safety of all our patients.

After considerable thought, weighing personal choice of whether to vaccinate or not versus the risk of acquiring a preventable disease while visiting our clinic, Primary Care West will request children that will not be immunized with Measles, Mumps and Rubella (MMR), and Diphtheria, Tetanus and Pertussis (DTaP) seek medical care elsewhere. Our clinicians strongly encourage all children be immunized according to the recommendations of the CDC, AAP and ACIP.

The only exception will be for children with a documented medical contraindication recognized by the CDC, AAP, and ACIP.