Registration Form
(Please Print)

Patient Information	**Email:**		
Patient's Last Name	**Patient's First Name**	**Middle:**	
Date Of Birth: ___/___/_____ **Social Security Number:_____-____-_____**	**Sex: Male Female**	**Marital Status: Sin/mar/div/sep/widow**	
Street Address/PO BOX:	**City**	**State**	**Zip**
Phone Number:	**Where did you hear about us?**		

Insurance Information Do you have Insurance? □ Yes □ No
Interested in seeing our certified assistance counselor? □ Yes □ No
Please give your insurance card, Medicaid or Medicare Card to Receptionist

Primary Insurance:	Secondary Insurance:
Person Responsible for Bill: (address if different)	Date of Birth: ____/____/_____

In Case of Emergency

Name of Relative or Friend:	Relationship:	Home #: Work #:

Please select your race:	**Please select your ethnicity:**
□ Asian □ Native Hawaiian □ Other Pacific Islander □ Black/African American □ American Indian/Alaska Native □ White □ More than one Race □ Unknown/Refuse to report	□ Hispanic/Latino □ Not Hispanic/Latino □ Unknown/Refused to Report

Living status: □Homeless Shelter □Transitional □Doubling up □Street □Own/rent □ Unknown

Language: (If best served in other than English)	**Are you a Veteran? □ Yes □ No**

ASSIGNEMENT AND RELEASE, the undersigned, have insurance coverage with _____and assign directly to HOPE Community Medicine, and associated healthcare providers all medical payments and benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the release of all information necessary to secure payments of benefits. I authorize the use of this signature on all insurance submission.

MEDICARE AUTHORIZATION request that payment of authorized Medicare benefits be made on my behalf to HOPE Community Medicine for any services furnished by their healthcare provider. I authorize the holder of medical information about me to release to the Health Care Financing Administration or appropriate agents, any information needed to determine these benefits payable to related services.

I understand my signature request that payments be made or authorizes the release of medical information necessary to pay the claim. If "the other health insurance" is indicated on the HCFA form or elsewhere on the approved claim forms of electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carries as the full charge, and the patient is responsible only for the deductible, coinsurance, and uncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare Carrier.

Patient/Guardian Signature _____Date _____

Rights and Responsibilities of Patient and HOPE Policy

Welcome to HOPE Community Medicine, where our goal is to provide quality health care to people, regardless of their ability to pay.

AS A PATIENT, YOU HAVE THE RIGHT TO:

- Take part in your healthcare and treatment
- Know the names of the persons caring for you
- Be treated with respect and dignity in a safe and private setting
- Be informed about your illness and treatment
- Get another opinion about your illness or treatment
- Privacy of your health records. Only legally authorized persons may access your health record unless you request in writing for us to present them for another person.
- Talk with the Clinic Manager about any questions or problems with your care. No HOPE representative will punish, discriminate or retaliate against you for filing a complaint.
- Access to health care that is reasonable for your condition and within our capability however, HOPE is *not* an emergency care facility.
- Ask for special arrangements if you have a disability.
- Ask for help with a living will or durable power of attorney for health care.
- Refuse treatment, care and services as allowed by law.
- Know the cost of your care, explanations of your bill and methods available to allow you to play for your care.
- Federal law prohibits HOPE Community Medicine from denying primary healthcare services which are medically necessary solely because you cannot pay for these services. You have a right to receive a copy of HOPE's Termination of Services policy. Services may be terminated if behavior is in violation of Rights and Responsibilities of patient and HOPE.

AS A PATIENT, YOU HAVE THE RESPONSIBILITY TO:

- Tell your medical provider about illnesses, problems, hospitalizations or Emergency Department visits.
- Ask questions about your illness or care and participate in your treatment.
- Show respect to both caregivers and other patients.
- Give staff accurate information about your present financial status or changes in status.
- Provide supervision of children you bring with you.
- Keep your scheduled appointments; cancellations or rescheduling should be done 24 hours in advance.
- Pay or arrange to pay your bills on time.

- Use medications or medical devices as directed by the provider for *yourself,* only.
- Inform your medical provider if your health worsens or you have an unexpected reaction to a medication.
- Give written permission to release your other health records to HOPE Community Medicine when necessary for continuity of care.
- Provide a copy of your living will or durable power of attorney for health matters.

Please ask your medical provider or Clinic Manager if you have questions.

Receipt of the Patient and HOPE Community Medicine's Rights and Responsibilities

I, _____, have read, understood and received a copy of the patient and HOPE Community Medicine's Rights and Responsibilities.

If signing for a minor, _____
(Print minors Name)

_____
Patient/Parent/Legal Guardian Signature

_____ _____
Witness Date

HIPAA Privacy Policy
Notice of Privacy Practices

Policy: HOPE Community Medicine will comply with all federal HIPAA and all state laws and regulations regarding the privacy of health information. In the regard, HOPE shall adopt, maintain current, and comply with its Notice of Privacy Practices, as amended from time to time.

Purpose: to insure compliance with all federal and state laws and regulations.

Procedures:

A. **Patient's Access to their medical records:** Patient of HOPE generally should be able to see and obtain copies of their medical records and request corrections if they identify errors and mistakes. HOPE, as a "covered entity," should generally provide access to its patients' medical records within thirty (30) days and may charge patients for its reasonable costs of copying and sending the records.

B. **Notice of Privacy Practices:** HOPE Community Medicine shall publish and provide a notice to its patients describing how we may use the patients' protected health information and its patients' rights under the HIPAA privacy regulations. HOPE shall provide its "Notice of Privacy Practices" on the patient's first visit or encounter, if possible, and upon request. Patients shall be asked to sign, initial or otherwise acknowledge that they received the Notice of Privacy Practices. In addition, HOPE shall post its current Notice of Privacy Practices in its waiting areas, and shall have copies available for distribution at the reception desk. Patients may ask the clinic to restrict the use or disclosure of their protected health information beyond the clinic's practices included in the Notice, but the clinic does not have to agree to the changes.

C. **Assigning Privacy and Security Responsibilities:** HOPE's Chief Operating Officer (COO) is responsible for implementing and maintaining the HIPAA privacy standards and the privacy policies and procedures manual. The chief operating officer may share the job responsibilities and duties with a designee if necessary. Further, HOPE shall ensure that this individual(s) will be provided sufficient resources and authority to fulfill their job duties and responsibilities. In this regard, it is the policy of HOPE that the responsibility for designing and implementing policies and procedures to implement this Privacy Policy Statement lies primarily with the COO.

D. **Limits on Use of Protected Health Information: Minimum necessary use and disclosure of protected health information:** The HIPAA privacy regulations sets limits on how HOPE, as a "covered entity" under HIPAA, may use protected health information. To promote the best quality care for patients, the HIPAA privacy regulations does not restrict the ability of HOPE providers and nurses to share information needed to treat their patients. However, protected health information generally may not be used for purposes not related to health care, and HOPE may use or share only the minimum amount of protected health information necessary for a particular purpose. In addition, patients need to sign a specific written authorization before HOPE could release

the patient's protected health information to a life insurer, a bank, a marketing firm or another outside business for purposes not related to the patients' health care.

Accordingly, it is the policy of HOPE Community Medicine that all routine and recurring uses and disclosures of protected health information by HOPE staff shall be limited to the minimum amount of information necessary to accomplish the purpose of the use or disclosure. Exceptions to this "minimum necessary" standard are uses or disclosures made:

1. For purposes of treatment
2. To or as authorized by the patient
3. As required by law

Non-routine uses and disclosures will be handled pursuant to HOPE's privacy policies and procedures. Except as stated above, all requests for protected health information shall be limited to the minimum amount of information needed to accomplish the purpose of the request.

E. **Prohibition on Marketing:** The HIPAA privacy regulations sets restrictions and limits on the use of protected health information for marketing purposes. As noted above, HOPE must first obtain the patient's specific authorization before disclosing patient protected health information for marketing purposes. At the same time, the HIPAA privacy regulations permits HOPE and its providers and nurses to communicate freely with its patients about treatment options and other health-related information, including disease-management programs.

In the regard, it is the policy of HOPE that any uses or disclosures of patient protected health information for marketing activities will be done only after HIPAA-compliant authorization has been obtained from the patient (or his/her personal representative). In addition, it is the policy of HOPE to consider marketing any communication intended to induce the purchase or use of a product or service where an arrangement exists in exchange for direct or indirect remuneration, or where HOPE encourages the purchase or use of a product or service directly to patients. HOPE does not consider the communication of alternate forms of treatment, or the use of products and services in treatment, or a face-to-face communication made by us to the patient, or a promotional gift of nominal value given to the patient to be marketing, unless direct or indirect remuneration is received from a third party and the communication is not to a health plan enrollee concerning:

1. A provider's participation in the health plan's network
2. The extent of covered benefits
3. The availability of more cost-effective drugs or pharmaceuticals, devices or biologics.

F. **Psychotherapy Notes; Mental Health Records:** HOPE shall require HIPAA compliant authorization for any use or disclosure of psychotherapy notes, as defined in the HIPAA regulations, except for treatment, payment or health care operations as follows:

1. Use by originator for treatment
2. Use for training physicians or other mental health professionals as authorized by the HIPAA regulations
3. Use or disclosure in defense of a legal action brought by the individual whose records are in issue
4. Use or disclosures as required by law, or as authorized by law to enable health oversight agencies to oversee the originator of the psychotherapy notes.

G. **Confidential Communications:** Under the HIPAA privacy regulations, patients can request that HOPE and its staff take reasonable steps to ensure that their communications with the patient are confidential. For example, a patient could ask to call his/her officer rather than home, and HOPE should comply with that request if it can be reasonable accommodated.

H. **HOPE and other covered entities:** The HIPAA privacy regulations require HOPE to establish policies and procedures to protect the confidentiality of its patients' protected health information. These requirements are flexible and permit different covered entities to implement them as appropriate for their businesses or practices. HOPE Community Medicine must provide all the protects for patients cited above, such as providing a "Notice of Privacy Practices" and limited the use and disclose of protected health information to only the minimum amount necessary for a particular purpose and as otherwise required under HIPAA.

I. **Written privacy policies and procedures:** The privacy regulations requires HOPE Community Medicine as a "covered entity" to have written privacy policies and procedures in place, including a description of staff who have access to protected health information, how it will be used and when it may be disclosed. HOPE generally must take steps to ensure that any of its "business associates" who have access to protected health information agree to the same limitations on the use and disclosure of protected health information.

J. **Reasonable Safeguards:** Reasonable safeguards shall be in place to protect protected health information from any intentional or unintentional use or disclosure in violation of the HIPAA privacy or security regulations. These reasonable safeguards will include physical protection of premises and protected health information, electronic technical protection and administrative protection. These reasonable safeguards extend to the oral communication of protected health information.

K. **Verification of Identity:** The identity of all persons who request access to protected health information shall be verified before such access is granted.

L. **Mitigation:** The effects of any unauthorized use or disclosure of protected health information shall be mitigated to the extent possible by HOPE and its staff.

M. **Business Associate Agreements:** It is the policy of HOPE that all its business associates shall execute business associate agreements that contractually bind the business associates to protect protected health information to the same extent as HOPE.

N. **Record Retention:** HOPE shall abide by the requirements set forth in the HIPAA privacy regulations that HIPAA privacy-related records shall be retained for six (6) years. All records designated by the HIPAA privacy regulations for this retention requirement shall be maintained in a manner that allows for access within a reasonable period of time. This records retention time requirement may be extended at HOPE's discretion to meet with other federal or state laws and regulations or those requirements imposed by FTCA.

O. **Employee training and awareness:** The HIPAA privacy regulations require HOPE to train its staff in its HIPAA policies and procedures; and the chief operating officer or assigned designee is responsible for ensuring that HOPE's HIPAA policies and procedures are followed. HOPE shall ensure that HOPE's HIPAA compliance program is current with federal and state laws and regulations. All HOPE staff members should be trained on HIPAA policies and procedures and the training should be documented in the employee file.

P. **Public Responsibilities:** In limited circumstances, the HIPAA privacy regulations permits (but does not require) HOPE a "covered entity" under HIPAA to continue certain existing disclosure of protected health information for specific public responsibilities. These permitted disclosures include:

1. Emergency circumstances
2. Identification of the body of a deceased person, or the cause of death
3. Public health purposes
4. Research that involves a "limited data set" or has been independently approved by an institutional review board or authorized privacy board
5. Oversight of the health care system
6. Judicial and administrative proceedings
7. Limited law enforcement activities
8. Activities related to national defense and security

The HIPAA privacy regulations generally establishes new safeguards and limits on these disclosures. In this regard, it is the policy of HOPE that its privacy protections extend to protected health information of its deceased patients.

Q. **Complaints:** All complaints regarding patient protected health information shall be investigated and resolved in a timely manner. In addition, all complaints shall be addressed to the chief operating officer (or designee) who is duly authorized to investigate complaints and implement resolutions if the complaints stems from a valid area of non-compliance with the HIPAA privacy and security regulations. The chief operating officer shall investigate

such complaints in conjunction with the chief executive officer, governing board, and legal counsel, as appropriate.

R. **Investigation and Enforcement; Full cooperation with privacy oversight authorities:** HOPE and its staff shall cooperate fully with all HIPAA oversight and enforcement agencies in their efforts to ensure the privacy and security of health information. As a condition of employment or contract, all staff shall cooperate fully with all compliance reviews and investigations. Staff members shall not be retaliated against for cooperation with any oversight and enforcement authority.

S. **Prohibited Activities: No Retaliation or Intimidation:** No HOPE staff member shall engage in intimidating or retaliatory acts against persons who file complaints or otherwise exercise their rights under HIPAA privacy or security regulations. In addition, no HOPE staff member shall condition treatment, payment, enrollment or eligibility for benefits on the provision of an authorization to disclose protected health information except as expressly authorized under the HIPAA law and regulations.

T. **Sanctions:** If HOPE is informed that a staff member failed to comply with federal (HIPAA) or state privacy laws and regulations or follow its privacy and security policies and procedures, HOPE must take appropriate disciplinary action and initiate sanctions. In this regard, sanctions shall be in effect for and HOPE staff member who intentionally or unintentionally violates any of the privacy policies or procedures. Such sanctions shall be documented in the staff member's file.

Approved this _____ day of May 2016

_____ _____
Keith Miller, M.D., Chief Medical Officer Date

_____ _____
Michael H. Belgard, PA, Chief Executive Officer Date

_____ _____
Kristi McClelland, Board Chairperson Date

NOTICE OF PRIVACY PRACTICES

PATIENT ACKNOWLEDGEMENT

I acknowledge I have received the Notice of Privacy Practices of HOPE Community Medicine.

Name: _____
Name of Patient/Patient Representative

By: _____ Date: _____
Signature or Patient/Patient Representative

_____
If Signed by Patient Representative, Indicate Relationship to Patient

If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement, and the reasons why the acknowledgement was not obtained. _____

_____

_____

_____

_____

By: _____ Date: _____
Signature of HOPE Representative

Name: _____ Title: _____
Name of HOPE Representative

Distribution: Original – Medical Record;

Copy – Patient/Patient Representative

Reconocimiento de Recibo del Aviso de Prácticas de Privacidad

En el curso de proveerle servicios, creamos, recivimos y almacenamos Informacion de Salud que lo indentifica. A menudo es necesario utilizar y revelar su informacion de Salud con el fin de tratalo, obtener pago for nuestros servicios, y para llevar a cabo operaciones de servicios de salud que implican nuestra oficina. El Aviso de Prácticas de Privacidad que se le ha dado describe estos usos y divulgaciones a detalle.

Si esta firmado como un representante personal del paciente, describa la relacion con el paciente la Fuente de autoridad para firmar esta forma:

_____ _____

Relacion con Paciente Nombre Escrito

Fuente de Autoridad: _____

Yo Autorizo la liberacion de mi Informacion de Salud Protejida a los siguientes individuos:

_____ _____
_____ _____
_____ _____
_____ _____

Reconozco que he recibido el Aviso de Las Practicas de Privacidad de HOPE Community Medicine

_____ _____

Firma Fecha

Acknowledgment of Notice of Privacy Practices

In the course of providing services to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services, and to conduct healthcare operations involving our office. The ***Notice of Privacy Practices*** you have been given describes these uses and disclosures in detail.

If signing as a personal representative of the patient, describe the relationship to the patient and the source of authority to sign this form:

_____ _____

Relationship to Patient Print Name

Source of Authority: _____

I Authorize the Release of my Protected Health Information to the following individuals:

_____ _____

_____ _____

_____ _____

_____ _____

I acknowledge that I have received the Notice of Privacy Practices from HOPE Community Medicine.

_____

_____**Signature** **Date**

General Consent for Treatment

Name of Patient: _____ Date of Birth: ____/____/____

Name of person giving consent if different from Patient:

[Print Name]: _____

Relationship to Patient: □ Self □ Parent □ Guardian □ Other: _____

I hereby and voluntarily consent to authorize HOPE Community Medicine's healthcare providers to provide health care services to me at HOPE Community Medicine's service location. The health care services may include, without limitation, routine physical and mental assessment; diagnostic and monitoring tests and procedures; examinations and medical and/or dental treatment; routine laboratory procedures and tests; x-rays and other imaging studies; administration of medications; and procedures and treatments prescribed by HOPE Community Medicine's healthcare providers. The health care services also may include counseling necessary to receive appropriate services including family planning (as defined by federal laws and regulations).

I understand that I will be asked to sign a separate informed consent for vaccines to be administered to me and that I will receive a "Vaccine Information Statement" (VIS) prior to receiving each vaccine. I understand that there is a separate consent form that I may be asked to sign to be tested for infectious conditions.

I understand that there are certain hazards and risks connected with all forms of treatment, and my consent is given knowing this.

I understand that this consent is valid and remains in effect as long as I am a patient of HOPE Community Medicine, until I withdraw my consent, or until HOPE Community Medicine changes its services and asks me to complete a new consent form.

Consent Provisions

My signature on this form indicates that:

1. I certify that I have read and fully understand the foregoing consent and that the facts indicated above are true.
2. I realize that although every effort will be made to keep all risks and side effects to a minimum, risks, side effects, and complications can be unpredictable both in nature and severity.
3. I understand that Nurse Practitioners, may be involved in my treatment and I consent thereto.
4. I understand that I may be asked to sign a separate informed consent form for certain Treatment(s) that require such.
5. I hereby voluntarily give my consent to Treatment at HOPE Community Medicine.

_____ _____

Signature of Patient/Legal Representative **Date/Time**

If signed by other than Patient, indicate relationship: _____

_____ _____

Witness Date

Medication History Consent

This consent will enable us to:

- Determine the pharmacy benefits and drug co pays for a patient's health plan
- Check whether a prescribed medication is covered (in formulary) under the patient's plan
- Display therapeutic alternatives with preference rank (if available) within a drug class for medication.
- Download a historic list of all medications prescribed for a patient by any provider.

In summary, we ask your permission to obtain formulary information, and information about other prescriptions prescribed by other providers using RxHub.

<u>All questions contained in this form are strictly confidential & will become a part of your medical record.</u>

I certify by my signature that I have provided all the information on any medical condition that I have been diagnosed or informed that I have. Also, I give permission for HOPE Community Medicine to access my pharmacy benefits data electronically through RxHub.

_____ _____

Patient/Parent/Guardian Signature **Date**

Do you have any of the following advanced Directives?

____Living Will

____DNR (Do Not Resuscitate) order

____Health Care Power of Attorney

In the event that a patient request assistance in the formulation of an advanced directive, the appropriate staff member will follow the states approved procedures to guide the individual to establish an advanced directive.


HOPE
community medicine