Coon Joint Replacement Institute

Coon Joint Replacement Institute
6 Woodland Road, Suite 202
St. Helena, CA 94574
Phone 877-747-9991
Fax 707-968-9580

Welcome to Coon Joint Replacement Institute

Thank you for contacting our office

We look forward to your appointment on _____/_____/_____ at _____ AM / PM with _____

Clinic Hours
Staff answer phones Monday through Friday 8:00 am – 5:00 pm. Scheduling an appointment in advance is strongly recommended as we may be unable to accommodate "walk-in" requests. If you have a medical emergency, please call 911 or go to the nearest emergency room.

Appointment Cancellations
If you are unable to keep your appointment, kindly let us know at least 24 hours in advance. Repeated "No Shows" may result in appointment scheduling delays or discharge from the practice.

Patient Information
Your name, current address, telephone number and insurance information will be verified at each visit.

Insurance Information
Please bring your insurance information, along with your insurance card(s) when you come in for an appointment. Co-pays and deductibles are part of the contract between you and your insurance carrier and, therefore, must be paid at the time of service.

Private Pay Patients
Full payment for services provided will be collected from private pay patients at the time of service, less a 78% discount. Please speak to the Practice Manager in advance of your appointment if alternative payment arrangements need to be discussed.

Billing Information
We are happy to bill your insurance company for the services provided by our practice. Please be aware, however, that you may also be billed separately by the hospital and/or specialty physicians for diagnostic services such as pathology, radiology, etc.

Medical Records
In order to compile a complete health record and provide you with the best possible care, please let us know if there are medical records we should request from another source.

Medications
Always bring a list of your medications (or the actual bottles), including the dosage and the name of the prescribing physician to appointments. Whenever possible, request prescription refills during office visits. Refills will be processed during normal business hours Monday through Friday only. Please allow one to two business days for routine medication refills. For refills between office visits, ask your pharmacy to send us a request.

Foreign Languages
If you have difficulty understanding English, please notify clinic staff prior to your appointment.

Thank you for choosing us for your healthcare needs!

PATIENT REGISTRATION FORM

(Please give your insurance card to the receptionist.)

*** Indicates required information to be completed by patient**

PATIENT INFORMATION				
***Last Name:**	***First Name:**	**Middle:** Suffix:		Preferred Name:
***Sex: ❑ M ❑ F**	***Date of Birth: / /**	Preferred Language:		Race:
Gender Identity (circle one): Choose not to Disclose / Female / FTM – Transgender Female to Male / Gender Queer / Male / MTF – Transgender Male to Female / Non-Binary / Other		Written Language:		***Ethnicity:**
Marital status (circle one): Divorced / Legally Separated / Life-Domestic Partner/ Married / Single / Unknown / Widowed		Religion:		Student Status:
Email Address:		***Social Security SSN: - -**		

MAILING ADDRESS				
***Mailing Address Line 1:**		Mailing Address Line 2:		
***Country:**	***Zip Code:**	***City:**	***State:**	***County:**

PHYSICAL ADDRESS (IF DIFFERENT FROM MAILING ADDRESS)				
Physical Address Line 1:		Physical Address Line 2:		
Country:	Zip Code:	City:	State:	County:

CONTACT INFORMATION			
***Home Phone:** **( )**	Mobile Phone: ( )	Work Phone: ( ) Ex:	Preferred Phone Type: (circle one) Home / Mobile / Work

EMPLOYER			
Employer:			
Employer Address Line 1:		Employer Address Line 2:	
Country:	Zip Code:	City:	State:
Business Phone: ( ) Ex.		Contact:	
Employment Status: (circle one) (Active Military Duty / Full-Time/ Never Employed / Part-Time / Retired / Self Employed / Unemployed / Unknown	Occupation:	Hire Date: / / End Date: / / Retire Date: / /	

PROVIDER	
***Primary Care Physician:**	Phone Number: ( )

Version 2.0 – Last Modified 7/25/2017

PATIENT REGISTRATION FORM

(Please give your insurance card to the receptionist.)

*** Indicates required information to be completed by patient**

MY ADVENTIST HEALTH (PATIENT PORTAL)		
I would like to sign up for My Adventist Health ❑ YES ❑ NO *If yes, complete this section.		
***E-Mail Address:**	***Challenge Question:** (circle one) Last four digits of your SSN? What Year did you graduate high school? What year was your first child born? What year was your mother born?	***Challenge Answer:**

GUARANTOR				
***Last Name:**	***First Name:**	**Middle:**		Preferred Name:
Suffix:				
***Sex: ❑ M ❑ F**	***Date of Birth: / /**		***Social Security SSN:**	
***Mailing Address Line 1:**			Mailing Address Line 2:	
***Country:**	***Zip Code:**	***City**	***State:**	***County:**
***Home Phone:** ( )	Mobile Phone: ( )	Work Phone: ( ) Ex.		E-mail Address:
Guarantor Employer:				
Employer Address Line 1:			Employer Address Line 2:	
Country:	Zip Code:	City:		State:
Business Phone:	Extension:		Contact:	
Employment Status (circle one): Active Military Duty / Full-Time / Never Employed / Part-Time / Retired / Self Employed / Unemployed / Unknown		Occupation:	Hire Date: / / End Date: / / Retire Date: / /	

RELATED PERSON				
Role (circle one): Emergency Contact / Guardian / Next of Kin / Power of Attorney		Type (circle one): Aunt / Brother / Cadaver Donor / Daughter / Employee / Father / Life Partner / M. Grandfather / M. Grandmother / Mother / Organ Donor / Other / P. Grandfather / P. Grandmother / Sister / Son / Spouse / Uncle		
Last Name: Suffix:	First Name:	Middle:		Preferred Name:
Sex: ❑ M ❑ F	Date of Birth: / /		Social Security SSN:	
Address Line 1:		Address Line 2:		
Country:	Zip Code:	City	State:	County:
Home Phone: ( )	Mobile Phone: ( )	Work Phone: ( ) Ex.		E-mail Address:

PATIENT REGISTRATION FORM

(Please give your insurance card to the receptionist.)

*** Indicates required information to be completed by patient**

INSURANCE				
Accident Related? ❑ yes ❑ No				
Name of **Primary** Health Plan:				
Insurance Address Line 1:		Insurance Address Line 2:		
Country:	Zip Code:	City:	State:	County:
Plan Begin Date: / /		Plan End Date: / /		
Member Number:	Group Number:	Group Name:		
Insured Name on Card: Last Name: Suffix:	First Name:	Middle Name:		

Name of **Secondary** Health Plan (if applicable):				
Insurance Address Line 1:		Insurance Address Line 2:		
Country:	Zip Code:	City:	State:	County:
Plan Begin Date: / /		Plan End Date: / /		
Member Number:	Group Number:	Group Name:		
Insured Name on Card: Last Name: Suffix:	First Name:	Middle Name:		

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Adventist Health or insurance company to release any information required to process my claims.

_____ _____

Patient/Guardian Signature Date

Guardian Name (print): _____

Office use only

Clinic site: _____

NPP given ❑ yes ❑ No Date: / /

MRN #: _____

Documented in CPM ❑ yes ❑ No

Label

Adventist Health | Coon Joint Replacement Institute

Medical History

Name _____ Today's Date_____

ILLNESSES/ MEDICAL PROBLEMS YOU HAVE HAD Check (✓) all that apply

- ❑ Anemia
- ❑ Arthritis
- ❑ Asthma
- ❑ Eczema, hives
- ❑ Epilepsy
- ❑ Diabetes
- ❑ Heart disease
- ❑ High blood pressure
- ❑ Eye problems
- ❑ Cancer, Type _____
- ❑ Kidney/ bladder problems
- ❑ High cholesterol
- ❑ Lung disease, tuberculosis
- ❑ Mental illness/ depression
- ❑ Liver disease, hepatitis, jaundice
- ❑ Substance abuse
- ❑ Stroke
- ❑ Phlebitis/blood clots
- ❑ Ulcer in stomach
- ❑ Uncontrolled bleeding
- ❑ Thyroid disease
- ❑ Other _____
- ❑ ***Check here if NONE apply***

PAST SURGERIES

_____ Date ____/____/____
_____ Date ____/____/____
_____ Date ____/____/____
_____ Date ____/____/____

PAST HOSPITALIZATIONS

_____ Date ____/____/ ____
_____ Date ____/____/ ____
_____ Date ____/____/ ____
_____ Date ____/____/ ____

MEDICATIONS (include dosage and frequency)

_____ _____
_____ _____
_____ _____

Do you need refills today? ❑ No ❑ Yes, medication(s) _____

ALLERGIES (describe reaction)

_____ Reactions _____
_____ Reactions _____

HABITS (include quantity**)**

Tobacco? ❑ No ❑ Yes Packs per week? _____ How long?_____
Alcohol? ❑ No ❑ Yes Drinks per week?_____ How long?_____
Caffeine? ❑ No ❑ Yes Cups per day? _____ How long?_____

FAMILY HISTORY

Member	Alive (A)	Deceased (D)	Age	Disease or Cause of Death
Mother	A	D	____	_____
Father	A	D	____	_____
Sibling	A	D	____	_____
Sibling	A	D	____	_____

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Review of Systems

Name _____ Today's Date_____

Check (✓) all that apply

GENERAL
❑ Fatigue
❑ Marked Weight Change
❑ Night Sweats ❑ Persistent Fever
❑ Sensitivity to Cold ❑ Sensitivity to Heat

BREAST
❑ Discharge ❑ Lumps

CARDIO RESPIRATORY SYSTEM
❑ BiPAP
❑ Bloody Sputum
❑ Bluish Fingers or Lips
❑ Chest Pain or Discomfort
❑ Cough, Persisting
❑ CPAP
❑ Difficulty Breathing While Lying Down
❑ High Blood Pressure
❑ Pain of Breathing ❑ Palpitations
❑ Shortness of Breath ❑ Sleep Apnea
❑ Sputum (Phlegm) ❑ Swelling of Ankles
❑ Vein Trouble ❑ Wheezing

DIGESTIVE SYSTEM
❑ Difficulty Swallowing
❑ Abdominal Distress
❑ Abdominal Enlargement
❑ Excess Gas ❑ Change of Appetite
❑ Constipation ❑ Dark Urine
❑ Diarrhea ❑ Heartburn
❑ Hemorrhoids ❑ Jaundice
❑ Nausea ❑ Need for Laxatives
❑ Rectal Bleeding ❑ Tarry Stools
❑ Vomiting ❑ Vomiting of Blood

EARS
❑ Discharge ❑ Loss of Hearing
❑ Ringing in Ears

ENDOCRINE
❑ Adrenal Trouble ❑ Cortisone Treatment
❑ Diabetes ❑ Thyroid Trouble

EYES
❑ Double Vision ❑ Eye Pain
❑ Glasses/ Contact Lenses
❑ Inflamed Eyes ❑ Trouble Seeing

GENITOURINARY SYSTEM
❑ Protein in urine
❑ Blood in Urine
❑ Feel Need to Urinate Without Urine
❑ Impotence
❑ Increase in Frequency of Urination (day)
❑ Increase in Frequency of Urination (eve)
❑ Lack of Sex Drive ❑ Pain / Burning
❑ Pain with Intercourse
❑ Unable to Hold Urine

MOUTH
❑ Bleeding gums ❑ Dental Problems
❑ Sore Gums ❑ Soreness of Tongue

MUSCULOSKELETAL *(Circle One)*
Cramps / Pain / Stiffness / Swelling / Weakness

Joint / Muscle_____
❑ Left ❑ Right ❑ Both
❑ Above occurs at rest
❑ Above occurs after walking
❑ Above occurs after
repetitive motion for _____ minutes

NOSE
❑ Excess Discharge ❑ Frequent Colds
❑ Loss of Smell ❑ Nosebleeds
❑ Obstruction ❑ Running Nose

NERVOUS SYSTEM
❑ Headaches ❑ Dizziness
❑ Fainting ❑ Seizures
❑ Nervousness ❑ Depression
❑ Change in Sensation
❑ Memory Loss ❑ Poor Coordination
❑ Weakness or Paralysis
❑ Suicidal Thoughts ❑ Anxiety

GYN-OB
Started Menstruating at Age _____
Date of Last PAP Test _____
Interval Between Periods _____
Days Duration _____ Days
Flow: ❑ Light ❑ Normal ❑ Heavy
Date of Last Period _____
Pain with Periods: ❑ Yes ❑ No
Duration_____ Days
Number of Pregnancies_____
Number of Miscarriages_____
At what age
did you have your first child?_____
Number of Births _____
Weight of Babies at birth _____

SKIN
❑ Change in Hair
❑ Change in Nails
❑ Change of Color

SLEEP DISORDERS
❑ Snoring ❑ Shortness of breath
❑ Excessive Sleepiness
❑ Pauses in Breathing While Sleeping
❑ Insomnia
❑ Sleeplessness

THROAT
❑ Hoarseness
❑ Postnasal Drainage
❑ Soreness

❑ ***Check here if NONE apply***

Reviewed by:
Doctor's initials _____
Date_____

Patient name _____ Med Rec. #_____ Date of birth _____

Conditions of Registration

1. **Medical and Procedural Consent:** I consent to the procedures that may be performed during my clinical visit. These may include office visits, non-complex blood tests or laboratory procedures, x-ray examinations, nursing, telehealth, e-visits and other services provided to me under the direction of my clinic provider. I understand that the practice of medicine is not an exact science and that my treatment may involve risks. I acknowledge that no guarantees have been made to me as a result of my examination or treatment in this clinic.
2. **Release of Information:** I have received a copy of the Notice of Privacy Practices (NPP), which describes when the clinic may use or disclose my information for treatment and payment. The NPP is incorporated into these Conditions of Registration and Financial Agreement by this reference. This notice is only provided the first time I receive services from the clinic and is otherwise available upon request. My legal rights relating to this information allows me to file a complaint if I believe my rights have been violated.
3. **Financial Agreement:** I accept financial responsibility for all services during my care. I am aware that my service may be offered at both a hospital based clinic and a non-hospital based clinic, and that I should check with my health insurance company about locations that may cost less. For any questions that I may have now or in the future, I can contact the staff in this clinic. I agree to promptly pay all bills for services during my care. Should the account be referred to an attorney or agency for collection, I will pay actual attorney's fees and collection expenses. All delinquent accounts are subject to interest at the legal rate. I hereby authorize the clinic and/or its agent(s) to request credit information from various credit reporting bureaus for the collection of my account including, but not limited to, collection of delinquent accounts, the evaluation of requests for financial assistance, and routine credit scoring.
4. **Financial Assistance:** I have been informed of Adventist Health's Financial Assistance policy. I understand more information about the policy can be found at facility registration area(s), the website AdventistHealth.org, by calling (844) 827-5047, or by writing Adventist Health ATTN: Financial Assistance PO Box 619122, Roseville, CA 95661.
5. **Assignment of Insurance Benefits:** I assign and authorize direct payment to the clinic of all insurance plan benefits that are payable for care. With this authorization, all parties agree that the insurance company's payment to the clinic shall satisfy the insurance company's obligations related to care. I further understand that I am financially responsible for charges not paid according to this assignment.
6. **Medicare Assignment:** I certify that the information given by me in applying for payment from any third party payer, including payment under Title XVIII of the Social Security Act, is correct. I request that payment of authorized benefits be made on my behalf, and I authorize the Social Security Administration Office of the Department of Health and Human Services to release information regarding my eligibility for coverage under Medicare Part A and Part B, including but not limited to the effective

date of such coverage. I also authorize my physician(s) to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim(s).

7. **Nondiscrimination:** I am informed that the clinic does not discriminate based on age, race, ethnicity, color, ancestry, religion, culture, language, physical or mental disabilities, socioeconomic status, sex, sexual orientation, and gender identity or expression. Additionally, I understand that room assignments are made based on gender identity.
8. **Personal Valuables:** I understand that I am responsible for all personal belongings. Adventist Health is not responsible for replacing lost or misplaced items.
9. **Legal Relationship between Clinic, Physicians and Mid-Level Providers:** Physicians and surgeons, including, but not limited to, primary care physicians, other clinic physicians, radiologists, pathologists, specialists, surgeons, and some nurse practitioners, physician assistants and midwives providing services to me are NOT employees of Adventist Health and have been granted the privilege of using the clinic for the care and treatment of their patients. Physicians may bill separately for their services. I understand that I am under the care and supervision of my attending physician. The clinic and its staff are responsible to carry out his/her instructions. My physician is responsible for obtaining my informed consent, when required, for specific medical treatment, special diagnostic or therapeutic procedures, or clinic services rendered to me under his/her general or special instructions. Notice to Consumer: physician assistants are licensed and regulated by the Physician Assistant Committee (916) 561-8780 www.pac.ca.gov. Medical doctors are licensed and regulated by the Medical Board of California (800) 633-2322 www.mbc.ca.gov.
10. **Photography:** I consent to the taking of photographs, videotapes, digital or other images, and surveillance monitoring for purposes of my diagnosis, treatment, or for the clinic's operations, including peer review, education or training programs conducted by the clinic. My consent will be requested for non-treatment photography such as marketing or external purposes.
11. **Consent to Telephone Calls for Financial Communications:** If the telephone number I have provided to the hospital is a wireless telephone number, I hereby consent to receive auto-dialed and/or pre-recorded calls, including debt collection calls, from or on behalf of the hospital at this number in the course of routine business communications.

I agree to accept financial responsibility for services rendered to the patient and to accept the terms of the financial Agreement and Assignment of Insurance Benefits.

I have read the above, received a copy, and am the patient OR I am the patient's legal representative OR I have been authorized by the patient to sign on his/her behalf.

Patient/Patient Representative Signature:

X Date:

Time: _____

_____
Printed Name

☐ I am the patient

☐ I am the patient's legal representative

☐ I have been authorized by the patient to sign on the patient's behalf

If you are not the patient, please identify your relationship to the patient:

☐ Spouse ☐ Legal Guardian ☐ Healthcare Power of Attorney

☐ Parent ☐ Guarantor ☐ Other (please specify)

Witness Signature and Title: (required for patients unable to sign or without a representative)

X Date:

Time: _____

_____
Printed Name

Interpreter Signature:

Interpreter Printed Name:

Language used for translation of document:

Date: Time:

Adventist Health | Coon Joint Replacement Institute

Authorization to Release Medical Information

I authorize the release of my medical information to the following family members and/ or others:

	Name	Relationship	Contact Number
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____

❑ Advance Directive (on file in chart) ❑ Durable Power of Attorney (on file in chart)

DATE _____ TIME _____ SIGNED _____
(Patient/Parent/Conservator/Guardian)

If signed by other than patient, indicate relationship_____

WITNESS _____

Adventist Health | Coon Joint Replacement Institute

Coon Joint Replacement Institute
6 Woodland Road, Suite 202
St. Helena, CA 94574
Phone 877-747-9991

Patient name _____ Date of Birth _____
Address _____ SS# _____
City/State/Zip _____ Phone _____

CHECK ONE: ❑ Please OBTAIN Information FROM
❑ Please SEND my medical information TO

Name of physician/
hospital/other _____
Street address _____
City/State/Zip _____
Phone # _____
Fax # _____

I AUTHORIZE THE RELEASE OF THE FOLLOWING RECORDS

_____
_____
_____
_____

For the purpose of: ❑ Patient care
❑ Self ❑ Insurance claim
❑ Other _____

List specific dates of records to be released.

Duration: This authorization shall begin immediately and shall remain in effect for one (1) year unless otherwise specified as follows:

❑ date _____

❑ event _____

Restrictions: I understand that the information released may be subject to re-disclosure by the recipient and may no longer be protected. (Under California law, however, a recipient of medical information, whether disclosed pursuant to an authorization or to the discretionary provisions of California Civil Code #56.10(x), may not further disclose that medical information except in accordance with a new authorization or as specifically required or permitted by law.)

Rights: I understand that I may refuse to sign this authorization and that my refusal to sign may not affect my ability to obtain treatment (see page 2 of this form for certain exceptions). I may inspect or obtain a copy of any information to be used and/or disclosed under this authorization in accordance with organizational policy. I understand that I have the right to revoke this authorization in writing (see reverse side of this form). My revocation will be effective upon receipt, but will not be effective to the extent that this organization has taken action in reliance upon this authorization.

DATE _____ TIME _____ SIGNED _____
(Patient/Parent/Conservator/Guardian)

If signed by other than patient, indicate relationship _____

WITNESS _____

* **For Office Use Only** *

Date received _____ Date records sent: _____ Medical record # _____

Notes _____

Clerk's Initials _____

Adventist Health | Coon Joint Replacement Institute

HIPAA; Notice of Privacy Practices

Provider: Coon Joint Replacement Institute
Effective Date: August 27, 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 Coon Joint Replacement Institute.

WHO WILL FOLLOW THIS NOTICE

This notice describes Adventist Health Providers' practices and that of:

- Any health care professional authorized to enter information into your medical record.
- All departments and units of the healthcare system.
- Any volunteer in our organizations.
- All employees, staff and other designated personnel (e.g., students, contracted agency staff).
- All these Providers, sites and locations follow the terms of this notice. In addition, these Providers, sites and locations may share medical information with each other for treatment, payment or healthcare operations purposes described in this notice.

OUR PLEDGE REGARDING MEDICAL INFORMATION

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive in our facilities. We need this record to provide you with quality care and to comply with certain legal requirements. Physicians (personal, consultants, specialists) involved in your care may have different policies or notices regarding the doctor's use and disclosure of your medical information created and/or maintained in the doctor's office or clinic.

This notice will tell you about the ways in which we may use and disclose medical information about you, via any medium (written, oral, or electronic). We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

We are required by law to:

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

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

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

Disclosure At Your Request. We may disclose information when requested by you. This disclosure at your request may require a written authorization by you.

For Treatment. We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, health care students, or other Provider personnel who are involved in taking care of you. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. In addition, the doctor may need to tell a dietitian if you have diabetes so that we can arrange for appropriate meals. Different departments of the Provider also may share medical information about you in order to coordinate the different things you need, such as prescriptions, lab work and x-rays. When you leave the Provider, we also may disclose medical information about you to people outside the Provider who may be involved in your medical care, such as skilled nursing facilities, home health agencies, caregivers, clergy, physicians or other practitioners. For example, we may give your physician access to your health information to assist your physician in treating you.

For Payment. We may use and disclose medical information about you so that the treatment and services you receive may be billed to you and payment may be collected from you, an insurance company or a third party. For example, we may need to give information about surgery you received at the Provider to your health plan so it will pay us or reimburse you for the surgery. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment. We may also provide basic information about you and your health plan, insurance company or other source of payment to practitioners outside the Provider who are involved in your care, to assist them in obtaining payment for services they provide to you.

For Health Care Operations. We may use and disclose medical information about you for healthcare operations. These uses and disclosures are necessary to manage the AH Provider and make sure that all of our patients receive quality care. For example, we may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine medical information about many of our patients to decide what additional services we should offer, what services are not needed, and whether certain new treatments are effective. We may also disclose information to doctors, nurses, tech-

nicians, medical students, and other Provider personnel for review and learning purposes.

We may also combine the medical information we have with medical information from other Providers to compare how we are doing and see where we can make improvements in the care and services we offer. We may remove information that identifies you from this set of medical information so others may use it to study health care and health care delivery without learning who the specific patients are.

Fundraising Activities. We may use information about you, or disclose such information to a foundation related to the AH Provider, to contact you in an effort to raise money for operations. You have the right to opt out of receiving fundraising communications. If you receive a fundraising communication, it will tell you how to opt out.

Provider Directory. We may include certain limited information about you in the Provider directory while you are a patient at the Provider hospital. This information may include your name, location in the hospital, your general condition (e.g., good, fair, etc.) and your religious affiliation. Unless there is a specific written request from you to the contrary, this directory information, except for your religious affiliation, may also be released to people who ask for you by name. Your religious affiliation may be given to a member of the clergy, such as a priest or rabbi, even if they don't ask for you by name. This information is released so your family, friends, and clergy can visit you while you're a patient at Provider hospital and generally know how you are doing.

Marketing and Sale. Most uses and disclosures of medical information for marketing purposes, and disclosures that constitute a sale of medical information, require your authorization.

Individuals Involved in Your Care. We may release medical information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. Unless there is a specific written request from you to the contrary, we may also tell your family or friends your condition and that you are a patient at the Provider.

In addition, we may disclose medical information about you to an organization assisting in a disaster relief effort so that your family can be notified about your condition, status and location. If you arrive at the emergency department either unconscious or otherwise unable to communicate, we are required to attempt to contact someone we believe can make health care decisions for you (e.g., a family member or agent under a health care power of attorney.)

Research. Under certain circumstances, we may use and disclose medical information about you for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another, for the same condition. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of medical information, trying to balance the research needs with patients' need for privacy of their medical information. Before we use or disclose medical information for research, the project will have been approved through this research approval process, but we may, however, disclose medical information about you to people preparing to conduct a research project, for example, to help them look for patients with specific medical needs, as long as the medical information they review does not leave the Provider..

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

To Avert a Serious Threat to Health or Safety. We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, if you were involved in a violent crime, disclosure may be made to law enforcement.

SPECIAL SITUATIONS

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

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

If you are a member of the Armed Forces, we may disclose medical information about you to the Department of Veterans Affairs upon your separation or discharge from military services. This disclosure is necessary for the department of Veterans Affairs to determine if you are eligible for certain benefits.

We may use and disclose medical information about you to components of the Department of Veterans Affairs to determine whether you are eligible for certain benefits.

Workers' Compensation. We may release medical information about you for workers compensation or similar work-related programs providing benefits.

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

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

- to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law;
- to notify emergency response employees regarding possible exposure to HIV/AIDS, to the extent necessary to comply with state and federal laws.

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

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

Law Enforcement. We may release medical information if asked to do so by a law enforcement official:
- In response to a court order, subpoena, warrant, summons or similar process;
- To identify or locate a suspect, fugitive, material witness, or missing person;
- About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
- About a death we believe may be the result of criminal conduct;
- About criminal conduct at the Provider; and
- In emergency circumstances to report a crime, the location of the crime or victims; or the identity, description or location of the person who committed the crime.

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

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

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

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

Multidisciplinary Personnel Teams. We may disclose health information to a multidisciplinary personnel team relevant to the prevention, identification, management or treatment of an abused child and the child's parents, or elder abuse and neglect.

Special Categories of Information. In some circumstances, your health information may be subject to restrictions that may limit or preclude some uses or disclosures described in this notice. For example, there are special restrictions on the use or disclosure of certain categories of information – e.g., tests for HIV or treatment for mental health conditions or alcohol and drug abuse. Government health benefit programs, such as Medi-Cal, may also limit the disclosure of beneficiary information for purposes unrelated to the program.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU

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

Right to Inspect and Copy. You have the right to inspect and receive a copy of your medical information that may be used to make decisions about your care. Usually, this includes medical and billing records, but may not include some mental health information.

To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to Coon Joint Replacement Institute. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect and receive a copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by the Provider will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Amend. If you feel that the medical 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 for as long as the information is kept by or for the Provider.

To request an amendment, your requested must be made in writing and submitted to Coon Joint Replacement Institute. In addition, you must provide a reason that supports your request.

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

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

Even if we deny your request for amendment, you have the right to submit a written addendum, not to exceed 250 words, with respect to any item or statement in your record you believe is incomplete or incorrect. If you clearly indicate in writing that you want the addendum to be made part of your medical record we will attach it to your medical records and include it whenever we make a disclosure of the item or statement you believe to be incomplete or incorrect.

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 other than our own uses for treatment, payment and health care operations (as those functions are described above), and with other exceptions pursuant to the law.

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

In addition, we will notify you as required by law following a breach of your unsecured protected health information.

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

We are not required to agree to your request, except when the disclosure is to a health plan or insurer for payment or health care operations purposes if you, or someone else on your behalf (other than the health plan or insurer), has paid for the item or service out of pocket in full. Even if you request this special restriction, we can disclose the information to a health plan or insurer for purposes of treating you.

If we do agree to another special restriction, we will comply with your request unless the information is needed to provide you emergency treatment.

To request restrictions, you must make your request in writing to Coon Joint Replacement Institute. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

Right to Request Confidential Communications. You have the right to request that we 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 must make your request in writing to Coon Joint Replacement Institute. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

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

To obtain a paper copy of this notice: Coon Joint Replacement Institute.

CHANGES TO THIS NOTICE

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

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the Provider or with the Secretary of the Department of Health and Human Services. To file a complaint with the Provider, contact the Privacy Officer at the following address: Attention: Privacy Officer, Adventist Health Physician Services, 1075 Creekside Ridge Drive Suite 100, Roseville CA 95678. All complaints must be submitted in writing.

You will not be penalized for filing a complaint.

OTHER USES OF MEDICAL INFORMATION

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. *If you revoke your permission, this will stop any further use or disclosure of your medical information for the purposes covered by your written authorization, except* if we have already acted in reliance on your permission. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

Coon Joint Replacement Institute
6 Woodland Road, Suite 202
St. Helena, CA 94574
Phone 877-747-9991

By signing this form, you acknowledge receipt of the "Notice of Privacy Practices" of Adventist Health Physicians Network. Our "Notice of Privacy Practices" tells you how we may use and disclose your protected health information. We encourage you to read it in full.

We may change our "Notice of Privacy Practice." If we change our notice, you may obtain a copy of the revised notice by accessing our website www.adventisthealth.org or by calling 916-865-1865.

If you have any questions about our "Notice of Privacy Practices," please contact the privacy officer at 916-865-1865.

I acknowledge receipt of the "Notice of Privacy Practices" of Adventist Health Physicians Network.

DATE _____ TIME _____ SIGNED _____
(Patient/Legal Representative)

If signed by other than patient, indicate relationship_____

Print name of Legal Representative _____

Office Use Only

Complete only if no signature is obtained. If it is not possible to obtain the individual's Acknowledgment, describe the good faith efforts made to obtain the individual's Acknowledgment, and the reason why the Acknowledgement was not obtained.

Reasons why the acknowledgment was not obtained:

- ❑ Patient refused to sign this Acknowledgment even though the patient was asked to do so, and the patient was given the Notice of Privacy Practices.
- ❑ Other_____

DATE _____ TIME _____ SIGNED _____
(Provider Representative)

Print name of Provider Representative_____

Adventist Health | Coon Joint Replacement Institute

St. Helena, CA

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Identification

Client name _____

Medical Record #_____

* 1 3 9 *
Consent / Refusal / Request / Release