



# Community Health Systems, Inc. (CHSI)

## Patient Consent Form

| CONSENT ITEMS                                                                                                                                                                                                                                                                                                                                                                       | PATIENT INITIALS |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|
| <b>CONSENT FOR TREATMENT:</b> I hereby authorize medical treatment for the below named.                                                                                                                                                                                                                                                                                             |                  |
| <b>RIGHTS AND RESPONSIBILITIES:</b> I hereby acknowledge that I have received a copy of CHSI's Patient Rights and Responsibilities. I further acknowledge that I will be offered a copy of any amendments upon request.                                                                                                                                                             |                  |
| <b>CALIFORNIA ADVANCE HEALTH CARE DIRECTIVE:</b> I hereby acknowledge that I have been given information regarding advance directives.                                                                                                                                                                                                                                              |                  |
| <b>HIPAA – NOTICE OF PRIVACY PRACTICES:</b> I hereby acknowledge that I have received a copy of CHSI's HIPAA - Notice of Privacy Practices. I further acknowledge that a copy of the current notice is made available / posted in the waiting area, and that I will be offered a copy of any amendments upon request.                                                               |                  |
| <b>MEDICAL HISTORY:</b> I hereby authorize CHSI to access my medical history, without limitation or exclusion, as is required and / or reasonably advisable to disclose, process, retrieve, transmit, and view my medical history.                                                                                                                                                  |                  |
| <b>INSURANCE:</b> I hereby authorize and request my insurance company to pay CHSI directly for my claims. I understand that my medical insurance carrier may pay less than the actual bill for services rendered and I agree to be responsible for any unpaid balances I or my dependents may incur.                                                                                |                  |
| I acknowledge that I have been informed that CHSI is federally funded and because of that they are required to ask me for my family size and income on a yearly basis.                                                                                                                                                                                                              |                  |
| I have elected to either provide staff with my family size and estimated gross yearly income OR elected not to provide the information.                                                                                                                                                                                                                                             |                  |
| I certify that I have read and understand this notice / authorization. I have been given an opportunity to ask any questions I may have regarding this notice. I acknowledge that my questions, if any, have been answered to my satisfaction. I understand that I may revoke this authorization at any time by written notice, except where information has already been released. |                  |
| I acknowledge receiving a copy of this document.                                                                                                                                                                                                                                                                                                                                    |                  |

**Patient's Name (print):** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Signature of patient/guardian:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**If not signed by the patient, please indicate the relationship:** \_\_\_\_\_

### Staff Use Only

#### Notice of Privacy Practices not Obtained

To be completed by CHSI when a patient's signed Acknowledgement form is not obtained.

Please check the box that best applies:

- ☐ Individual refused to sign.
- ☐ An emergency situation prevented us from obtaining the acknowledgement.

Comment: \_\_\_\_\_



## **Community Health Systems, Inc. (CHSI)**

### **Patient Rights and Responsibilities**

Members of our health centers have rights and responsibilities. Their rights protect them as health care consumers. Members also need to understand their responsibilities in order for their doctors and others who care for them to do their best job.

#### **Members Rights:**

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- Receive information about CHSI, its services and its doctors and other providers in a way that may be easily understood.
- Be treated with respect and dignity.
- Choose a Primary Care Physician from within your network of providers.
- Participate with your doctor in decision making about your health care, and to refuse treatment.
- File a complaint about CHSI or the care you receive.
- Request an interpreter (cost as applicable)
- Have your medical records kept private.
- Make arrangements to view your medical records.
- Make recommendations regarding CHSI's rights and responsibilities policies.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation. Exercise these rights without adversely affecting how you are treated by CHSI, its providers, or the State.

#### **Members Responsibility:**

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- Give correct information to CHSI, its doctors and other providers so that they can care for you.
- Follow the plans and care instructions that you have agreed to with your doctor and others who provide care to you.
- Bring your member ID card(s) with you when getting medical care. If you have other insurance, provide that card too.
- Keep follow-up visits with your doctor.
- Provide 24 hours' notice if you have to cancel an appointment
- Treat all CHSI personnel and health care providers respectfully and courteously.
- It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance company.



# Community Health Systems, Inc. (CHSI)

## Advance Health Care Directive

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### **INTRODUCTION TO YOUR CALIFORNIA ADVANCE HEALTH CARE DIRECTIVE**

This packet contains a legal document, a California Advance Health Care Directive that protects your right to refuse medical treatment you do not want, or to request treatment you do want, in the event you lose the ability to make decisions yourself.

Your California Advance Directive has five parts. Depending on your advance planning needs, you may complete any or all of the first four parts. However, **you must complete part 5.**

### **How do I make my California Advance Health Care Directive legal?**

You must sign and date your advance directive or direct an adult to do so for you if you are unable to sign it yourself, either of which must be witnessed before a notary public or two adult witnesses.

### **Your two adult witnesses cannot be:**

- your healthcare provider or an employee of your healthcare provider,
- the operator or an employee of a community care facility,
- the operator or an employee of a residential care facility for the elderly, or
- the person you have appointed as an agent, if you have appointed an agent.

In addition, one of your witnesses must be unrelated to you by blood, marriage, or adoption and not entitled to any portion of your estate.

If you are a patient in a skilled nursing facility when you execute your advance directive, one of your witnesses must be a patient advocate or ombudsman.

### **Whom should I appoint as my agent?**

Your agent is the person you appoint to make decisions about your healthcare if you become unable to make those decisions yourself. Your agent may be a family member or a close friend whom you trust to make serious decisions. The person you name as your agent should clearly understand your wishes and be willing to accept the responsibility of making healthcare decisions for you.

### **Your agent cannot be:**

- your supervising healthcare provider,
- the operator of a community care facility or residential care facility where you are receiving care, or
- the employee of a healthcare institution where you are receiving care or employee of a community care facility or residential care facility where you are receiving care, unless:
  - the employee is related to you by blood, marriage, or adoption,
  - the employee is your registered domestic partner, or
  - the employee is your coworker at the facility or institution.

You can appoint a second and third person as your alternate agents. An alternate agent will step in if the person(s) you name as agent is/are unable, unwilling, or unavailable to act for you.

### **Should I add personal instructions to my advance directive?**

Yes! One of the most important reasons to execute an advance directive is to have your voice heard. When you name an agent and clearly communicate to them what you want and don't want, they are in the strongest position to advocate for you. Because the future is unpredictable, be careful that you do not unintentionally restrict your agent's power to act in your



## Community Health Systems, Inc. (CHSI) Advance Health Care Directive

best interest. Be especially careful with the words “always” and “never.” In any event, be sure to talk with your agent and others about your future healthcare and describe what you consider to be an acceptable “quality of life”.

### **When does my agent’s authority become effective?**

Ordinarily, your advance directive only becomes effective when you have been determined by your medical team to be unable to make your own decisions. In California, however, you have a choice between making your agent’s authority effective immediately or only after a physician determines and documents that you are unable to make decision on your own behalf. Even when you make your agent’s authority immediate, you retain the primary authority for your healthcare decisions as long as you are able to make your wishes known.

### **Agent Limitations**

Your agent, if you appoint one, does not have authority to authorize convulsive treatment, psychosurgery, sterilization, or abortion, or to have you committed or placed in a mental health treatment facility.

Your agent will be bound by the current laws of California as they regard pregnancy and termination of pregnancies.

### **What if I change my mind?**

Except for the appointment of your agent, you may revoke any portion or this entire advance directive at any time and in any way that communicates your intent to revoke. This could be by telling your agent or physician that you revoke, by signing a revocation, or simply by tearing up your advance directive.

In order to revoke your agent’s appointment, you must either tell your supervising healthcare provider of your intent to revoke or revoke your agent’s appointment in a signed writing.

If you execute a new advance directive, it will revoke the old advance directive to the extent of any conflict between the two documents.

Unless you specify otherwise, if you designate your spouse as your agent, that designation will automatically be revoked by divorce or annulment of your marriage.

### **Mental Health Issues**

These forms do not expressly address mental illness, although you can state your wishes and grant authority to your agent regarding mental health issues. The National Resource Center on Psychiatric Advance Directives maintains a website (<https://nrc-pad.org/>) with links to each state’s psychiatric advance directive forms. If you would like to make more detailed advance care plans regarding mental illness, you could talk to your physician and an attorney about a durable power of attorney tailored to your needs.

### **What other important facts should I know?**

Be aware that your advance directive will not be effective in the event of a medical emergency, except to identify your agent. Ambulance and hospital emergency department personnel are required to provide cardiopulmonary resuscitation (CPR) unless you have a separate physician’s order, which are typically called “prehospital medical care directives” or “do not resuscitate orders.” DNR forms may be obtained from your state health department or department of aging (<https://www.hhs.gov/aging/state-resources/index.html>). Another form of orders regarding CPR and other treatments are state-specific POLST (portable orders for life sustaining treatment) (<https://polst.org/form-patients/>). Both a POLST and a DNR form MUST be signed by a healthcare provider and MUST be presented to the emergency responders when they arrive. These directives instruct ambulance and hospital emergency personnel not to attempt CPR (or to stop it if it has begun) if your heart or breathing should stop.



**Your Information.  
Your Rights.  
Our Responsibilities.**

*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.*

**Your Rights**

**When it comes to your health information, you have certain rights.** This section explains your rights and some of our responsibilities to help you.

|                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|---------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Get a copy of your health and claims records</b>           | <ul style="list-style-type: none"><li>You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.</li><li>We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.</li></ul>                                                                                                                                                                            |
| <b>Ask us to correct your medical record</b>                  | <ul style="list-style-type: none"><li>You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.</li><li>We may say “no” to your request, but we’ll tell you why in writing within 60 days.</li></ul>                                                                                                                                                                                                                                                                        |
| <b>Request confidential communications</b>                    | <ul style="list-style-type: none"><li>You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.</li><li>We will say “yes” to all reasonable requests.</li></ul>                                                                                                                                                                                                                                                                                                          |
| <b>Ask us to limit what we use or share</b>                   | <ul style="list-style-type: none"><li>You can ask us <b>not</b> to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say “no” if it would affect your care.</li><li>If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say “yes” unless a law requires us to share that information.</li></ul>      |
| <b>Get a list of those with whom we’ve shared information</b> | <ul style="list-style-type: none"><li>You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.</li><li>We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.</li></ul> |
| <b>Get a copy of this privacy notice</b>                      | <ul style="list-style-type: none"><li>You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.</li></ul>                                                                                                                                                                                                                                                                                                                     |

## Your Rights *continued*

|                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
|--------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Choose someone to act for you</b>                         | <ul style="list-style-type: none"> <li>• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.</li> <li>• We will make sure the person has this authority and can act for you before we take any action.</li> </ul>                                                                                                                                                                                                                                                                                                 |
| <b>File a complaint if you feel your rights are violated</b> | <ul style="list-style-type: none"> <li>• You can complain if you feel we have violated your rights by contacting us using the information on page 1.</li> <li>• You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to: <ul style="list-style-type: none"> <li>• 200 Independence Avenue, S.W., Washington, D.C. 20201,<br/>Calling 1-877-696-6775, or visiting <a href="http://www.hhs.gov/ocr/privacy/hipaa/complaints/">www.hhs.gov/ocr/privacy/hipaa/complaints/</a>.</li> </ul> </li> <li>• We will not retaliate against you for filing a complaint.</li> </ul> |

## Your Choices

**For certain health information, you can tell us your choices about what we share.** If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

|                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|-----------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>In these cases, you have both the right and choice to tell us to:</b>                            | <ul style="list-style-type: none"> <li>• Share information with your family, close friends, or others involved in your care</li> <li>• Share information in a disaster relief situation</li> <li>• Include your information in a hospital directory</li> </ul> <p><i>If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.</i></p> |
| <b>In these cases we <i>never</i> share your information unless you give us written permission:</b> | <ul style="list-style-type: none"> <li>• Marketing purposes</li> <li>• Sale of your information</li> <li>• Most sharing of psychotherapy notes</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>In the case of fundraising:</b>                                                                  | <ul style="list-style-type: none"> <li>• We may contact you for fundraising efforts, but you can tell us not to contact you again.</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                      |

## Our Uses and Disclosures

**How do we typically use or share your health information?** We typically use or share your health information in the following ways.

|                                                     |                                                                                                                                                                        |                                                                                                               |
|-----------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------|
| <b>Help manage the health treatment you receive</b> | <ul style="list-style-type: none"> <li>We can use your health information and share it with other professionals who are treating you.</li> </ul>                       | <b>Example:</b> A doctor treating you for an injury asks another doctor about your overall health condition.  |
| <b>Run our organization</b>                         | <ul style="list-style-type: none"> <li>We can use and share your health information to run our practice, improve your care, and contact you when necessary.</li> </ul> | <b>Example:</b> We use health information about you to manage your treatment and services.                    |
| <b>Pay for your health services</b>                 | <ul style="list-style-type: none"> <li>We can use and share your health information to bill and get payment from health plans or other entities.</li> </ul>            | <b>Example:</b> We give information about you to your health insurance plan so it will pay for your services. |

### How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: [www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html)

|                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
|--------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Help with public health and safety issues</b>                                     | <ul style="list-style-type: none"> <li>We can share health information about you for certain situations such as: <ul style="list-style-type: none"> <li>Preventing disease</li> <li>Helping with product recalls</li> <li>Reporting adverse reactions to medications</li> <li>Reporting suspected abuse, neglect, or domestic violence</li> <li>Preventing or reducing a serious threat to anyone's health or safety</li> </ul> </li> </ul>                   |
| <b>Do research</b>                                                                   | <ul style="list-style-type: none"> <li>We can use or share your information for health research.</li> </ul>                                                                                                                                                                                                                                                                                                                                                   |
| <b>Comply with the law</b>                                                           | <ul style="list-style-type: none"> <li>We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.</li> </ul>                                                                                                                                                                                                       |
| <b>Respond to organ and tissue donation requests</b>                                 | <ul style="list-style-type: none"> <li>We can share health information about you with organ procurement organizations.</li> </ul>                                                                                                                                                                                                                                                                                                                             |
| <b>Work with a medical examiner or funeral director</b>                              | <ul style="list-style-type: none"> <li>We can share health information with a coroner, medical examiner, or funeral director when an individual dies.</li> </ul>                                                                                                                                                                                                                                                                                              |
| <b>Address workers' compensation, law enforcement, and other government requests</b> | <ul style="list-style-type: none"> <li>We can use or share health information about you: <ul style="list-style-type: none"> <li>For worker's compensation claims</li> <li>For law enforcement purposes or with a law enforcement official</li> <li>With health oversight agencies for activities authorized by law</li> <li>For special government functions such as military, national security, and presidential protective services</li> </ul> </li> </ul> |
| <b>Respond to lawsuits and legal actions</b>                                         | <ul style="list-style-type: none"> <li>We can share health information about you in response to a court or administrative order, or in response to a subpoena.</li> </ul>                                                                                                                                                                                                                                                                                     |

CHSIs Fallbrook clinic is the only facility which creates and maintains psychotherapy notes.

CHSI is mandated to follow the Mandated Blood Testing and Confidentiality to Protect Public Health - California Health & Safety Code sections 120975-121020. This law protects the privacy of individuals who are the subject of blood testing for antibodies to the probable causative agent of acquired immune deficiency syndrome (AIDS)

CHSI will not share certain health information concerning a minor child (>13 yrs. old) with a parent unless permitted by the minor child as demonstrated in the following examples:

- **Example:** A State law provides an adolescent the right to obtain mental health treatment without the consent of his or her parent, and the adolescent consents to such treatment without the parent's consent.
- **Example:** A physician must receive the permission from the child (13 and over) to disclose information concerning a child's sexual activity or sexual health

CHSI provides immunizations records to local schools upon request from the school.

### Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: [www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html).

### Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

This notice is effective as of

**This Notice of Privacy Practices applies to the following organizations.**

*The notice applies to **Community Health Systems, Inc.** health centers and pharmacies within **Riverside, San Bernardino, and San Diego counties.***