Dear Families,

Welcome to The Children's Service Center of Casa Colina Hospital & Centers for Healthcare! We are proud of the outstanding services and resources that we have available for you and your child. We take seriously our aim to deliver the best care you can find. Our staff is committed toward the goal of treating your child and family as our own. Know that we are here for you. Please let us know if we miss the mark.

The following will be helpful to ensure things run smoothly:

1. Please wait outside until we have screened you and your child. There is a doorbell to the left of the door you can push when you arrive to notify us you are here.
2. Co-pays (when applicable) are due upon sign-in. Services will not be provided if co-payments are not paid.
3. Multiple cancellations per month will be reviewed for possible placement on a non-reserved, call-in type schedule. Numerous children are on the referral list and they will be put in your child's slot if attendance becomes a problem. Multiple "no shows" without calling prior to the scheduled appointment time will lead to removal of your child from the schedule.
4. We understand there are times you will need to cancel an appointment without advanced warning. If your child is ill, please keep them home and call us. If your child has had a fever within 24 hours, has vomited, or has excessive runny nose and/or cough, please keep them at home.
5. If applicable, please make sure we have your cell phone number. If we need to contact you at the last minute, you may already be in transit. Also, let us know of any changes in address, telephone number, insurance coverage, and/or physician relationships as they occur.
6. Children will not be able to participate in the services provided at CSC if immunizations are not up to date. If for a personal reason, you do not have your child immunized, please provide us with written documentation from your physician.
7. Keeping prescriptions and authorizations current is an on-going task. It is ultimately your responsibility to ensure both are up to date. Our clerical staff will assist you if needed. Failure in these areas may result in lapse of services or billing you directly for the services provided.

8. While we make every effort to keep your child's therapist(s) consistent, there will be times, necessitated by school meetings, vacations, illness, etc. when your child will be seen by other well-qualified therapists. Thank you in advance for your flexibility. Please notify us if you would rather miss a session than have another therapist see your child in such cases.
9. We have a training center for many professional school programs. As a result, your child may have the privilege of working with an intern in the intent on learning the professional skills for which they have studied so hard. Interns are closely supervised by their master clinician. Please feel free to discuss any concerns you have if they should arise.
10. During non-pandemic times: Supervision by an adult is required of all children at all times on the playground. Due to the number of children served, we ask you keep siblings out of the therapy rooms/gyms. Siblings are welcomed, with close supervision, in Early Start Classes. Additionally, equipment in the gym areas, classrooms and therapy rooms is only for therapy use with qualified staff.
11. Please arrive on time for your therapy or class. Equally as important, please be there to pick up your child at the scheduled conclusion of their session. We follow clinical hour timelines: 45-50 minutes of direct treatment for one-hour session, and 30-35 minutes of direct treatment for 45-minute sessions. The remaining 10-15 minutes of therapy time allows for set-up and charting. It is unfair to other children to have their session delayed while a staff member is attending to a child whose parent is late. Additionally, you lose out on critical communication time with your child's therapist pertaining to your child's care.
12. If your child is diapered or needs assistance with toileting, please make every attempt to stay on the premises to be available to assist with toileting needs.
13. We take the safety of your child seriously. In order to maintain a safe treatment environment, all clients are required to sign in when they arrive for services and receive a visitor's badge. When we complete therapy with your child, we will ask for your visitor badge as a way to ensure that the child is being returned to the same caregiver that dropped them off. If a different caregiver will be picking up the child from therapy, they need to be on the approved pick up list and they will be required to show an ID.
14. Know that we appreciate and respect the selfless dedication you give to your child.

If at any time, you have concerns regarding your child's program, please do not hesitate to speak with our Director, Michele Alaniz, OTR/L, or our Family Coordinator, Susan Stroebel, B.S.

We look forward to our time together. Remember our goal is to treat your child as one of our own. Casa Colina's earliest years were founded upon the desire to serve the needs of the children with extraordinary care. That is what drives us today and will carry us into tomorrow. Thank you for trusting us in this effort.

Sincerely,

The Staff of The Children's Center

Please sign below indicating you have read and understand the information provided in this letter.

X_____ Dated: X_____

Witness: _____ Dated: X_____

CASA COLINA
Hospital and Centers for Healthcare

CHILDREN'S SERVICES-INTAKE INFORMATION

Referral for: ☐OT ☐PT ☐ST ☐Early Start ☐START

Date of Referral: _____ Name of Contact Information: _____

Patient Name: _____ DOB: _____

Address: _____ City: _____ Zip Code: _____

Patient's SS#: _____ Language: English other: _____

Guardian's Name: _____ SS#: _____

Cell Phone: _____

Guardian's Name: _____

Cell Phone: _____

Address (if different from above) : _____

City: _____ Zip Code: _____

Email Address: _____

Home Telephone #: _____ Work Telephone #: _____

Referring Source: _____

Physician's Name: _____

Physician's Phone #: _____

Diagnosis: _____

Concerns/Reason for Referral: _____

****For Physician Referral:

Has the child had any recent surgery, hospitalization, illness? ☐YES ☐NO

- If yes, please describe date & details: _____

OTHER COMMENTS/CONTACTS/ADDITIONAL INFORMATON, PLEASE LIST BELOW:

_____
_____
_____
_____
_____

INSURANCE INFORMATION

Insurance Company: _____ Pager: _____

Address: _____ City: _____ Zip Code: _____

Phone #: _____

Insured Name: _____ SS#: _____

Policy #: _____

Group Name & Number: _____

What type of plan is this? ☐ HMO ☐ PPO ☐ Other _____

Outpatient Benefits: _____

_____
_____
_____
_____

CASA COLINA CHILDREN'S SERVICES CENTER
Parent Intake Questionnaire

PLEASE PRINT CLEARLY

CHILD AND FAMILY PROFILE:

Child's Name: _____ Date of Birth:_____ Today's Date:_____
Person completing questionnaire: _____Relationship to child:_____
Parent's/Guardian's Name:_____
Home Telephone Number: _____ Cellular Phone Number: _____
Email Address: _____
Address: _____
_____

Are parents: ☐ Married ☐ Not Married ☐ Separated ☐ Divorced
Other people living in the household: _____
Does the child have any siblings? (If yes how many do they have and what are their ages?)_____
_____

SERVICES:

Program	Currently receives and how much? (ex. 1 time a week)	Received in the past and how much? (ex. 1 time a week)	Name of facility	Specialist's Name and Phone Number
Pediatrician				
Neurologist				
Early Intervention				
Occupational Therapy				
Speech Therapy				
Physical Therapy				
Day Care				
Other:				

Who referred your child for this evaluation? _____
Reason for seeking therapy:
_____
_____
_____

Medical/Health History:

Current diagnoses: _____
Date diagnosed: _____ Age at diagnosis:_____
Who diagnosed the child: _____

Complications during pregnancy? ☐ Yes ☐ No. If yes, please describe. _____
_____
Born Full-Term: ☐ Yes ☐ No. If no, at how many weeks? _____ Birth Weight? _____
Complications after birth? ☐ Yes ☐ No. If yes, please describe. _____

Feeding difficulties as a newborn or infant? ☐Yes ☐No. If yes, please describe.

_____

Has your child ever been hospitalized and if so, when/why? _____

_____

Does your child have chronic ear infections or have tubes in the ears? _____
Date of last hearing test? _____ What were the results? _____
Date of last vision test? _____ What were the results? _____
Any medical tests (blood, allergy, MRI, EEG, etc.) or developmental tests (i.e., psychologist)?
☐Yes. ☐No. If yes, when and what were the results? _____

_____

Current medications (and describe purpose and frequency)_____
Please list any allergies: _____
Does your child have any special dietary restrictions: _____
Does your child sleep through the night? ☐Yes ☐No.
Does your child have a current immunization record?
☐Yes (Please provide front office with a copy) ☐No (Please see front office staff for opt out form)

Developmental Milestones

Indicate at what age your child acquired the following skills. If your child cannot do the skill, write NA.
_____ Rolled over _____ Independent sitting _____ Independent standing
_____ Walked _____ Spoke first words

Educational History

Does, or has, your child attend(ed) preschool? ☐Yes ☐No
If so, where:_____ School District: _____ How long? _____
Indicate the name of the elementary, middle or high school, and school district, that your child is currently attending. _____
Teacher's Name:_____ Current Grade Placement:_____
Has the teacher expressed any specific difficulties your child may have in and/or outside of the classroom? ☐Yes ☐No If so, please list:_____

_____

Has your child received any testing or special services through the public school system?
☐Yes ☐No If so, please explain:_____
Does your child currently receive learning assistance through school? ☐Yes ☐No If so, how often:_____
Does your child have a current Individualized Education Plan (IEP)? ☐Yes ☐No

What are your concerns about your child's participation in daily activities?

_____

_____

LEARNING STYLE

What do you feel is a barrier to your child's education/learning? Check all that apply:

☐Language
☐Cognitive
☐Attention/Learning
☐Vision
☐Hearing
☐Emotional
☐Physical
☐Communicative
☐Motivational
☐Pain
☐Cultural
☐Religious

To better interact with your child's therapist, what is your preferred learning style?
Check **ALL** that apply:

- ☐ Demonstration (i.e. Parent prefers to watch the therapist work with the child and return the demonstration by imitating parts of the presentation that work for the child)
- ☐ Visual Learning (i.e. Parent prefers reading written material for theory and techniques or strategies)
- ☐ Auditory Learning (i.e. Parent prefers to hear all about the theory and techniques or strategies)
- ☐ Through Experiences (i.e. Parent prefers that the therapist demonstrate the technique on the parent so that they can learn by feeling the experience, to feel the precise pressure, timing and subtleties of the presentation)
- ☐ A combination of approaches (i.e. Discussion, demonstration, participation, experiences, hand-outs, notes, pictures, drawings, videotapes, and instant camera pictures.)

What goals do you have for your child in therapy? (related to gross motor skills, fine motor skills, speech and language, self care, or sensory integration) _____
_____
_____
_____

CHILD PROFILE:

What are your child's strengths?_____
What are your child's favorite activities? _____
Least favorite?_____
What motivates your child best? _____

DEVELOPMENTAL SKILLS

	Always Independent	Needs Help	Completely Dependent/ Does Not Do
Self-Help Development			
Takes off socks and shoes (circle one)	☐	☐	☐
Puts on socks and shoes (circle one)	☐	☐	☐
Takes off jacket	☐	☐	☐
Pulls down pants	☐	☐	☐
Takes off pants	☐	☐	☐
Pulls up pants	☐	☐	☐
Puts on pants	☐	☐	☐
Takes off shirt (t-shirt)	☐	☐	☐
Puts on shirt (t-shirt)	☐	☐	☐
Able to unbutton buttons	☐	☐	☐
Able to button buttons	☐	☐	☐
Able to manage zippers	☐	☐	☐
Able to snap/unsnap (circle one)	☐	☐	☐
Ties shoes	☐	☐	☐
Brushes Teeth	☐	☐	☐
Wash hands	☐	☐	☐
Brushes hair	☐	☐	☐
Bathes self	☐	☐	☐

Is your child motivated to attempt dressing tasks (for example, attempts to remove socks but is unsuccessful)? _____

_____

Is your child toilet trained? _____

Able to clean self? _____

	Always Independent	Needs Help	Completely Dependent/ Does Not Do
Feeding Development			
Eats solid foods	☐	☐	☐
Eats a variety of foods	☐	☐	☐
Sits at table	☐	☐	☐
Feeds self with fingers	☐	☐	☐
Feeds self with spoon/fork (circle one)	☐	☐	☐
Drinks from a regular cup	☐	☐	☐
Sucks from a straw	☐	☐	☐
Cuts foods with a knife and fork	☐	☐	☐
Get self a drink of water from the tap	☐	☐	☐
Gets self a simple snack	☐	☐	☐
Prepares a simple meal	☐	☐	☐

Do you have any concerns about your child's eating patterns (for example, very picky eater)?

☐ Yes ☐ No If yes, please describe

_____

_____

Does your child need reminding to use a spoon instead of eating with his/her hands?

☐ Yes ☐ No

Community Involvement

Is your child involved in any community activities, such as sports teams, Boy Scouts, etc? Please list:_____

Does your child like to go out into the community (for example, the park, store, restaurant)?

☐ Yes ☐ No Please describe: _____

Is your child safe when in the community (holds your hand, stays close to you)? _____

_____

Play/Social Development

What are your child's favorite toys, activities, TV shows/videos/music?

_____

Does your child play with the toys appropriately? _____

_____

What play activities is your child able to do independently at home? _____

_____

Does your child play these favorite toys/activities with other children, parents, or alone?

☐ other children ☐ parents ☐ alone

Does your child have good eye contact with adults and with other children?

_____

_____

How does your child relate to his/her siblings (do they play together/what do they play)?

_____

_____

Does your child show interest in other children? ☐ Yes ☐ No If yes, how does he/she show that interest? _____

_____

How does your child do with other people visiting your home? _____

_____

Does your child ride a two wheeled bike? ☐ Yes ☐ No Describe: _____
Is your child able to swim independently? ☐ Yes ☐ No Describe: _____

Emotional/Behavioral Development

Check any of the following which have been and/or currently are a problem with your child.

	Daily Problem	Weekly Problem	Past Problem	Not a Problem
Difficult to discipline				
Easily upset				
Temper tantrums				
Poor eye contact				
Prefers to be alone				
Poor sleeping patterns				
Destructive with objects/property				
Self-injurious				
Aggressive with others				
Unusually active				
Unusually inactive				
Difficulty with siblings				
Difficulty with other children				
Difficulty receiving/giving affection				
Easily frustrated				

Language Development

Do you have any concerns about you child's speech/language? ■ Yes ☐ No If yes, please describe._____

_____

_____

For what reasons does your child communicate?

☐ To express needs ☐ To express emotions ☐ To request activities/objects
☐ To interact with others ☐ To share information

Does your child understand verbal instructions? ☐ Most of the time ☐ Some ☐ Very little
Please give examples of directions/comments your child follows/understands at home (e.g., time for a bath, get your shoes, give me the ball). _____

_____

_____

Do you use gestures/actions to help your child understand verbal directions? ☐ Yes ☐ No

Did your child ever begin to use words and then stop babbling/speaking? ☐ Yes ☐ No
If yes, At what age did your child begin speaking? _____ At what age stopped? _____

Are other languages than English spoken at home? _____

Does you child speak clearly (articulation)? ☐ Yes ☐ No

How does your child express frustration? _____

Does your child…	Frequently	Sometimes	Rarely Never	Age first occurred
Use single words?				
Combine words (e.g., more juice)?				
Speak in sentences?				
Use familiar sayings/phrases?				
Repeat words?				
Try to repeat sounds/words when asked?				
Copy gestures (clapping, finger plays)?				
Use sign language?				

PERFORMANCE SKILLS:

Does your child follow the daily routine and/or transitions:
☐ With ease, consistently ☐ Requires assistance ☐ Tantrums/resists transitions
How does your child respond to challenging/non-routine events? _____
_____
Frustration Tolerance: ☐ Average ☐ Poor
Activity level for daily activities: ☐ Appropriate ☐ High ☐ Low
Does your child rush through work/effortful activities? ☐ Yes ☐ No

SOCIAL/PLAY SKILLS:

Initiates interaction with others: ☐ Yes ☐ No If yes, does your child have friends outside of the family? _____
Responds to other's interactions: ☐ Yes ☐ No
Follows social conventions (appropriate for social group expectations): ☐ Yes ☐ No
Complies with adult directions/rules: ☐ Always ☐ Sometimes ☐ Never
What areas of their social/play skills need improvement? _____
_____
_____

ATTENTION TO ACTIVITIES:

☐ focuses on task until completion without individual assistance
☐ requires repeated redirection
☐ other: _____

ORGANIZING SPACE AND OBJECTS:

Is your child able to find routinely-used objects in room, class, desk, or backpack quickly when needed?	☐ Yes ☐ No
Does your child return routinely-used materials and objects to their storage location?	☐ Yes ☐ No
Is your child able to maintain participation in a large room/open space?	☐ Yes ☐ No
Does your child initiate activities?	☐ Yes ☐ No
Is your child able to engage in a multi-step activity (i.e. craft)?	☐ Yes ☐ No
Is your child able to sequence/time task?	☐ Yes ☐ No
Does your child engage in new/unfamiliar activities?	☐ Yes ☐ No
Is your child able to get on/off, in/out playground equipment, etc?	☐ Yes ☐ No
Does your child follow actions in songs or class (i.e. holiday/event) presentations?	☐ Yes ☐ No

VISUAL PERCEPTUAL:

Does your child have difficulty telling the difference between similar symbols such as b and p, + and x?	☐ Yes ☐ No
Does your child have difficulty finding an object in a group of other objects, such as in a cluttered drawer, or among other toys?	☐ Yes ☐ No
Does your child have difficulty discriminating between changes in surface levels, such as stepping off a curb or mat?	☐ Yes ☐ No
Does your child have difficulty controlling eye movements, such as following a ball with his/her eyes?	☐ Yes ☐ No

OTHER:

Please provide below or on a separate sheet of paper, any other information you wish for us to know, or feel would be beneficial, in our comprehensive assessment of your child. Also include copies of any recent report cards, evaluation reports or academic paperwork.

All information is held in the strictest of confidence.

Thank you for providing us with the opportunity to assist your child and family.

Please return this form to:
Casa Colina
Children's Services Center; Building #10
255 E. Bonita Ave.
Pomona, CA 91769-6001 Fax #: 909-596-3548 Phone #: 909-596-7733 Ext. 4200

CASA COLINA
Hospital and Centers for Healthcare

PATIENT SUMMARY LIST

Outpatient Services

Patient Name: _____ Date: _____

Do you have **Diabetes**? ☐ Yes ☐ No
If YES, have you been hospitalized or been admitted to the emergency room in the last 6 months due to high or low blood sugar? ☐ Yes ☐ No

Known **Diagnosis** and **Conditions**:

_____ _____
_____ _____

Known Significant **Surgical** and **Invasive Procedures:**

_____ _____
_____ _____

Known **Allergic Drug Reactions**:

_____ _____
_____ _____

Known **Medications**:

Medication(s)	Dose	Frequency	Current (✓)	Date Started	Date Discontinued

History of resistant bacteria: ☐ Yes ☐ No If YES, notify infection control nurse
History of immunizations: ☐ Current ☐ Copy provided ☐ Opt out ☐ If Opt out, see form

Updated by: _____ Date: _____ Time:_____ _____ Date: _____ Time:_____
_____ Date: _____ Time:_____ _____ Date: _____ Time:_____
_____ Date: _____ Time:_____ _____ Date: _____ Time:_____
_____ Date: _____ Time:_____ _____ Date: _____ Time:_____
_____ Date: _____ Time:_____ _____ Date: _____ Time:_____

Patient Information Sticker

Casa Colina Hospital and Centers for Healthcare
Children's Services Center

Missed Appointment and Late Policy

Here at Casa Colina's Children's Services Center each patient is important to us and for this reason *we request that patients do their best to attend all scheduled appointments*. We realize that occasionally an appointment needs to be cancelled and we request that all cancellations be made at least 24 hours in advance of the appointment time. Please contact the front desk at 909-596- 7733 ext. 4200. We have an operator here Monday through Friday from 8am to 5 pm. You may also leave a voice message.

Cancelled or Missed Appointments: If you cancel or re-schedule your appointment within 24 hours or no-show for an appointment you may be charged a $10.00 fee. A pattern of poor attendance over the course of your treatment will result in the cancellation of your future appointments. You may need to return to your physician before additional appointments are scheduled. A new prescription for services may be required. If you would like further details on our cancellation policy, please request a copy of the full policy and procedure from the front desk.

_____
Initial

Late Appointments: If you arrive late for a therapy session, every attempt will be made to accommodate you. However, the appointment may be rescheduled to the next available opening on the therapists' schedule. If you arrive 20 minutes late or later you may not be seen that day, you may be given the option of attending the remainder of the treatment, or you may be given the option of rescheduling to another time (all applicable co-payments and cancellation fees will apply regardless of length of treatment.)

Thank you for choosing Casa Colina Children's Services Center. We appreciate your understanding and cooperation in achieving our mutual goal of maximizing the benefits of your outpatient therapy.

Outpatient Operations

_____ _____
Patient/Guardian Signature Date

CASA COLINA
Hospital and Centers for Healthcare

OPPORTUNITY FOR PATIENT TO OBJECT TO USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION FOR CERTAIN PURPOSES

Patient's Name: _____

Address: _____

City: _____ **State:** ___ **Zip Code:** _____

Home Telephone: _____ **Date of Birth:** _____

I understand that **CASA COLINA HOSPITAL AND CENTERS FOR HEALTHCARE** has a Notice of Privacy Practices (the "Notice"). I hereby acknowledge that by my review of the Notice and this form, **CASA COLINA HOSPITAL AND CENTERS FOR HEALTHCARE** has informed me that my health information may be used or disclosed for one or more of the four purposes described below.

I further understand that **CASA COLINA HOSPITAL AND CENTERS FOR HEALTHCARE** will not disclose any of My Highly Confidential Health Information (as defined herein) pursuant to this Permission Form. "**My Highly Confidential Health Information**" includes psychotherapy notes and the subset of Protected Health Information that is related to:

(1) treatment of mental health and developmental disabilities; (2) alcohol and drug abuse prevention and treatment; (3) HIV/AIDS testing, diagnosis or treatment; (4) communicable disease(s); (5) genetic testing; (6) child abuse and neglect; (7) domestic and elder abuse; or (8) sexual assault.

PURPOSES:

1. **CASA COLINA HOSPITAL AND CENTERS FOR HEALTHCARE's** Directory. Use of the following pieces of Protected Health information about me to maintain a directory of individuals in Casa Colina's Inpatient, Ambulatory Surgery, Observation, and Residential facilities and disclosure of such information for directory purposes to members of the clergy and persons who ask for me by name.
   a. my name;
   b. my location in **CASA COLINA HOSPITAL AND CENTERS FOR HEALTHCARE;**
   c. my condition described in general terms that do not communicate specific medical information; AND
   d. my religious affiliation (which information may only be disclosed to members of the clergy).
2. For Involvement of Others in My Care. Disclosure of my Protected Health Information to a family member, other relative, close personal friend, domestic partner, significant other or any other person identified by me, that is directly relevant to that person's involvement with my care or payment for my care.
3. For Notification of My Location, General Condition or Death. Disclosure of my Protected Health Information to notify (or assist in the notification of) persons as identified in #2 above, of my location, general condition or death.
4. For Disaster Relief Efforts. Disclosure of my Protected Health Information to a public or private entity authorized to assist in disaster relief efforts in order to coordinate efforts to notify (or assisting in the notification of) those listed in #2 of my location, general condition or death.

Shared
Opportunity to Object to PHI Disclosures
1008

CASA COLINA
Hospital and Centers for Healthcare

OPPORTUNITY FOR PATIENT TO OBJECT TO USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION FOR CERTAIN PURPOSES

5. In addition, the inpatient rehabilitation program utilizes schedule boards to provide patients, families, therapists, nursing, and other patient care personnel with information to assist patients in knowing their schedule for attendance at therapy sessions. This board is posted in the Rehabilitation units and includes the disclosure of the name ofthe patient.
6. Casa Colina Hospital has collaborated with CommonWell to offer accessibility to the HealthInformation Exchange (HIE). CommonWell is a not-for-profit trade association; devoted to the visionthat health data should be available to individuals and caregivers regardless of where care occurs.The HIE connects the health care community and enables the sharing of information electronicallyand securely to improve quality ofhealth care services.

I acknowledge that CASA COLINA HOSPITAL AND CENTERS FOR HEALTHCARE has provided me with the opportunity to:

1) agree to the uses or disclosures described above;
2) request restrictions on some of these uses or disclosures; or
3) prohibit these uses or disclosures.

By my signature below, I hereby agree to the following
(Please check <u>one</u> of the boxes below):

☐ the use and disclosure of my health information for all of the six purposes described above.

☐ the use and disclosure of my health information only for the following purposes.
(Please check the applicable purpose(s)):

☐ 1 (Facility Directory)
☐ 2 (Involvement of Others in My Care)
☐ 3 (Notification of My Caregiver)
☐ 4 (Disaster Relief Efforts)
☐ 5 (Schedule Boards for inpatient programs only)
☐ 6 (Enroll in CommonWell for Health Information Exchange only)

☐ The use and disclosure of my health information for all of the six purposes described above, subject to the following restriction(s):

☐ By my signature below, I hereby prohibit the use and disclosure of my health information for all of the above listed purposes.

Printed Name of Patient or Authorized Representative

Relationship | Patient Signature or Authorized Representative | Date/Time

Shared
Opportunity to Object to PHI Disclosures
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AGREEMENT ON THE USE OF ELECTRONIC MAIL FOR PATIENT COMMUNICATIONS

This Agreement on the Use of Electronic Mail for Patient Communications ("Agreement") is entered into as of this ___ day of _____, 201__ between CASA COLINA HOSPITAL AND CENTERS FOR HEALTHCARE (the "Entity") and _____, an individual patient of the Entity (the "Patient").

RECITALS

WHEREAS, the Entity and Patient believe that the use of e-mail will enhance communications between Patient, the Entity and the Entity's clinical providers ("Providers") regarding Patient's care and treatment, and may also serve to expedite administrative matters related to health care services rendered to Patient;

WHEREAS, Patient has a confidential Entity-patient relationship with one or more Entity staff members or Providers and has been previously examined at the Entity; and

WHEREAS, the Entity and Patient wish to set forth in writing their understanding regarding the use of e-mail communications, in order to establish clear guidelines for the use of such communications.

NOW THEREFORE, in consideration of the promises and mutual covenants herein contained, the ongoing medical services rendered to Patient by the Entity, and other valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties agree as follows:

1. Use of E-mail Communications. Patient agrees and understands that Patient may use e-mail to communicate with Providers regarding Patient's care and treatment, and with the Entity regarding certain administrative matters arising from health care services rendered to Patient. Patient shall not use e-mail to communicate with Providers and shall use other means of communication (e.g., telephone, personal visit) for:

(a) emergencies or other time-sensitive issues;

(b) inquiries which deal with sensitive information; and

(c) situations in which a Provider's or the Entity's response is delayed.

The Entity and Providers shall make a reasonable attempt to return all e-mail messages received within two (2) business days. Notwithstanding the foregoing, if Patient does not receive a response by the close of business on the second business day following Patient's e-mail message, Patient agrees to use other means of communication to contact the Entity or Provider. Similarly, Patient agrees that Entity and Providers may use their reasonable professional judgment to determine whether any response by e-mail is appropriate or practical, and request that Patient either speak with the Entity or Provider by telephone or make an appointment for an in-person visit.

2. Composing E-mail Messages. When composing e-mail messages to Providers, Patient shall:

(a) Write concisely.

(b) Include Patient's full name and birth date, and patient identification number, if known, in the subject line, and a brief description of the nature of the request (e.g., "prescription refill", "medical advice", "billing question").

(c) Keep copies of e-mail messages sent and received.

(d) When requested by Provider, send a reply to the Provider to acknowledge receipt and review of e-mail message from Provider.

3. Access to Patient's E-mail Communications. By entering into this Agreement, Patient understands and acknowledges that it may be necessary for Providers other than the Provider to whom the message is addressed to access e-mail messages sent by Patient to the Provider, in order to help Provider organize and respond to e-mail messages received from patient, to cover for Provider if Provider is not available, and, in some cases, to assist in generating a response. Patient hereby authorizes any Provider of the Practice to access Patient e-mail messages. Further, the Practice may use non-clinical personnel to organize and respond to e-mail messages regarding billing or other administrative matters. Patient hereby authorizes non-clinical personnel of the Practice to access e-mail messages sent to Providers or Practice, which include inquiries related to administrative matters.

4. No Liability. Patient agrees that e-mail communications with the Entity and any Provider is offered as a convenience to Patient, and Patient shall not hold the Entity or Provider responsible for any expense, loss, or damage caused by, or resulting from: (i) a delay in Entity's or Provider's response to Patient, or any damage to Patient resulting from such delay, due to technical failures, including, but not limited to, technical failures attributable to the Entity's internet service provider, power outages, failure of the Practice's electronic messaging software, failure by Entity, Providers or Patient to properly address e-mail messages, failure of the Entity's computers or computer network, or faulty telephone or cable data transmission; (ii) any interception of Patient's, Providers', or Entity's e-mail communications by a third party; or (iii) Patient's failure to comply with the guidelines regarding use of e-mail communications set forth in Section 1, above.

5. Confidentiality. The Entity and Providers shall exercise reasonable efforts to ensure the confidentiality of Patient e-mail communications, however, Patient understands that e-mail communications to the Practice are not secure, and there is therefore some possibility that the confidentiality of such communications will be breached by a third party. **Communication regarding highly confidential medical matters should therefore be reserved for other forms of communication (e.g., telephone, personal visit)**. If Patient accesses the Entity through an employer's e-mail system, Patient should be aware that an employer has the right to review any e-mail communications transmitted through the employer's e-mail system.

6. Archiving. The Entity may keep copies of e-mail messages that Patient sends to Providers or the Entity, and may include such messages in patient's medical record.

7. Termination. This Agreement may be terminated by the Entity if the Entity determines that the Patient has failed to comply with its provisions. Upon Termination of this Agreement, the Entity will no longer respond to the patient's e-mail communications in the regular course of providing services to the patient. However, the Entity shall reserve the right to respond to any e-mail communications from the patient, if the Entity determines that such a

response is appropriate or practical.

8. Miscellaneous. This Agreement shall constitute the entire understanding between the parties with respect to e-mail communications, and shall supersede any prior understanding or agreement between the parties, whether oral or written. This Agreement shall be governed by, and construed in accordance with, the laws of the State of California. Entity may assign this agreement to a successor to all or substantially all of the stock or assets of the Entity.

IN WITNESS WHEREOF, this Agreement has been executed by Entity and Patient as of the day and year first above written.

ORGANIZATION:	PATIENT:
By_____	_____
Print Authorized Signatory	**[Print Patient's Name]**
_____	_____
Authorized Signatory	Patient Signature

CASA COLINA
Hospital and Centers for Healthcare

CONSENT TO PHOTOGRAPH/RECORD AND AUTHORIZATION FOR USE OR DISCLOSURE

CONSENT TO PHOTOGRAPH/RECORD: AUTHORIZATION FOR USE AND DISCLOSURE

I, _____(Name of Patient/Person), hereby consent to be photographed/recorded while receiving treatment at or while otherwise involved with Casa Colina Hospital and Centers for Healthcare (such as patient, family member, staff, or visitor). The term "photograph" includes video or still photography, in digital or any other format, and any other means of recording or reproducing images, audio recordings, or narrative use of my medical and personal history. This consent includes my permission to have those photographs or recordings transmitted by physical or electronic means such as email or by any other means to be invented, in conformance with the purposes stated below.

I hereby authorize the use of the photography/recording by or disclosure of the photography/recording to:

☐ Casa Colina Hospital and Centers for Healthcare, 255 East Bonita Avenue, Pomona, CA 91767

☐ Other:
(Persons/Organizations authorized to *receive* the information)(Address – street, city, state, zip code)

PURPOSE

I hereby authorize the use or disclosure of the photography/recording for the following uses or purposes (describe permitted uses, e.g., dissemination to Casa Colina Hospital and Centers for Healthcare staff, physicians, health professionals, and members of the public for educational, treatment, research, scientific, public relations, marketing, news media, and charitable purposes):

_____

_____

_____

I consent to be photographed/recorded and authorize the use or disclosure of such photography/recordings in order to assist scientific, treatment, educational, public relations, and/or charitable goals, and I hereby waive any right to compensation for such uses by reason of the foregoing authorization. I and my successors or assigns hereby hold the hospital, its employees, my physician(s), and any other person participating in my care and their successors and assigns harmless from and against any claim for injury or compensation resulting from the activities authorized by this agreement.

Patient Label or:
Patient Name:
MR#:

Account #:

MY RIGHTS

THIS AUTHORIZATION IS FOR UNLIMITED USAGE WITHOUT RESTRICTION UNLESS OTHERWISE REVOKED IN WRITING.

I may inspect or obtain a copy of the photograph whose use or disclosure I am authorizing.

I have a right to receive a copy of this Authorization.

Information disclosed pursuant to this Authorization could be re-disclosed by the recipient. Such re-disclosure is in some cases not protected by California law and may no longer be protected by federal confidentiality law (HIPPA).

If this box [ ] is checked, Casa Colina Hospital and Centers for Healthcare will receive compensation for the use or disclosure of my photograph(s).

SIGNATURE

Date:_____ Time:_____

Signature:_____
(person photographed/recorded or representative/spouse/financially responsible party)

If signed by someone other than the patient, state your legal relationship to the patient.

_____

Witness:_____

Patient Label or:
Patient Name:
MR#:

Account #:

CASA COLINA HOSPITAL AND CENTERS FOR HEALTHCARE CONDITIONS OF ADMISSION FOR OUTPATIENT SERVICES

For the purposes of this document, the term "patient" or "I" means the patient, the patient's legal representative (e.g. parent, conservator, guardian, healthcare power of attorney), or residential clients of Casa Colina Hospital and Centers for Healthcare (hereafter referred to as Casa Colina).

CONSENT TO MEDICAL, THERAPY, AND SURGICAL PROCEDURES

I consent to the procedures that may be performed during this episode of care or while I am an outpatient. These may include, but are not limited to emergency treatment or services, laboratory procedures, X-ray examinations, medical, therapy, or services provided to me under the general and special instructions of my physician or surgeon. I understand that the practice of medicine and therapies is not an exact science and that diagnosis, treatment, and therapies may involve risks of injury or even death. I acknowledge that no guarantees have been made to me regarding the result of examination, treatment, or therapy in Casa Colina.

LEGAL RELATIONSHIP BETWEEN HOSPITAL AND PHYSICIANS

All physicians providing services to me, including the radiologist, have been granted the privilege of using Casa Colina for the care and treatment of patients, but they are not employees, representatives or agents of Casa Colina. They are independent practitioners. These physicians will bill separately for their services.

Patient initials: _____

I understand that I am under the care and supervision of my attending physician. Casa Colina and its therapy and other clinical staff are responsible for carrying out my physician's instructions. My physician or surgeon is responsible for obtaining my informed consent, when required, for medical, special diagnostic or therapeutic procedures, or services provided to me under my physician's general and special instructions.

Patient Label or
Patient Name:
MR#:

Account #:

FINANCIAL AGREEMENT

I agree to promptly pay all Casa Colina bills I incur in accordance with the charges listed in Casa Colina's chargemaster and, if applicable, Casa Colina's charity care and discount payment policies and state and federal law. I understand that I may review Casa Colina's chargemaster before (or after) I receive services from Casa Colina. I understand that all physicians including the radiologist, will bill separately for their services. If any account is referred to an attorney or collection agency for collection, I will pay actual attorneys' fees and collection expenses. All delinquent accounts shall bear interest at the legal rate, unless prohibited by law.
Patient initials: _____

ASSIGNMENT OF ALL RIGHTS AND BENEFITS

The undersigned authorizes, whether he/she signs as an agent or as the patient, assignment and transfer to Casa Colina all rights, benefits, and any other interests in connection with any insurance plan, health benefit plan, or other source of payment for my care. This assignment shall include assigning and authorizing direct payment to Casa Colina of all insurance and health plan benefits payable for this hospitalization or for these outpatient services. The undersigned agrees that the insurer or plan's payment to Casa Colina pursuant to this authorization shall discharge its obligations to the extent of such payment. The undersigned understands that he/she is financially responsible for charges not paid according to this assignment, to the extent permitted by state and federal law. The undersigned agrees to cooperate with, and take all steps reasonably requested by this hospital to perfect, confirm, or validate this assignment.

HEALTH PLAN CONTRACTS

Casa Colina maintains a list of health plans with which it contracts. A list of such plans is available upon request from the Inpatient Admissions office, the outpatient registration area, or on the Casa Colina website at casacolina.org. All physicians and surgeons, including the radiologist, pathologist, anesthesiologist, and others, will bill separately for their services. It is my responsibility to determine if Casa Colina or the physicians providing services to me contract with my health plan. The undersigned agrees that he/she is individually obligated to pay the full charges of all services rendered to the patient by Casa Colina if the patient belongs to a plan that does not appear on the above mentioned list.

FINANCIAL ASSISTANCE

If you do not have insurance coverage, you MAY qualify for financial assistance. Casa Colina Hospital and Centers for Healthcare has a program to assist uninsured low income patients with discounted or charity care for Casa Colina services. Casa Colina may also agree to assist with setting up payment plans for those persons needing this type of assistance. For more information regarding your eligibility

Patient Label or
Patient Name:
MR#:

Account #:

for financial assistance, or for setting up a payment plan, please ask the Admissions or Registration Department staff for assistance, or call the Director of Patient Accounting at (909) 596-7733 Ext. 2166 or Ext. 3254.

CHARGEMASTER

To provide you with information you need to make healthcare decisions, Casa Colina makes available to you Chargemaster information. The Chargemaster is a comprehensive list of all services, supplies, and procedures offered at Casa Colina Hospital and Centers for Healthcare, along with their corresponding charges. This is the master list used to create a patient's bill. Our Chargemaster is available for your review by appointment in our Patient Financial Services Department. Estimate of your bills are available upon request. Please contact Patient Financial Services for assistance at (909) 596-7733 Ext. 2166 or 3254.

CONSENT TO PHOTOGRAPH

I hereby consent to be photographed while receiving treatment at Casa Colina. The term **"photograph"** as used herein, includes video or still photography, in digital or any other format, and any other means of recording or reproducing images.

I understand that the images from such photography may be used for my diagnosis, treatment, or therapy, or for Casa Colina's health care operations such as training and education programs, peer review or medical education, as my treating physician(s) or other clinical staff deem appropriate.

Photography for other purposes such as research, publication, outside education, marketing, public relations, or news or documentary requires an additional consent form be obtained.

PARTICIPATION IN EDUCATION PROGRAMS

Unless Casa Colina is notified to the contrary in writing, as part of the health education program of this institution, residents and students associated with approved affiliated programs may observe or participate in patient care or in activities that support patient care. These individuals may be present during treatments and procedures and may perform limited services under the supervision of Casa Colina physicians or other qualified persons for supervision of their activities.

Patient Label or
Patient Name:
MR#:

Account #:

Information on Quality of Care

Online resources are available to you concerning the quality of care provided by hospitals and healthcare systems nationwide.

Joint Commission on Accreditation of Healthcare Organizations
http://www.qualitycheck.org/

Hospital Compare
http://www.hospitalcompare.hhs.gov

HealthGrades
http://www.healthgrades.com

ACKNOWLEDGEMENT OF RECEIPT OF THE NOTICE OF PRIVACY PRACTICES

By initialing this section, I acknowledge receipt of the "Notice of Privacy Practices" of Casa Colina. The "Notice of Privacy Practices" explains how Casa Colina may use and disclose my protected health information. Casa Colina encourages me to read it in full.

Casa Colina may change the "Notice of Privacy Practices". If the notice should change, I may obtain a copy of the revised notice by:

- Accessing Casa Colina's website at www.casacolina.org; or
- Contacting the Admissions Department at (909) 596-7733 or toll free (866) 724-4127 ext. 3900; or
- Contacting the Outpatient Services Department at (909) 586-7733 or toll free (866) 724-4127 ext. 3500; or
- Contacting Casa Colina's Privacy Officer at (909) 596-7733, ext. 3410

Patient initials: _____

If it is not possible to obtain the patient or the patient's representative's Acknowledgement for the receipt of the Notice of Privacy Practices, describe the good faith efforts made to obtain the individual's Acknowledgement, and the reasons why the Acknowledgement was not obtained:

☐ *Patient refused to sign this Acknowledgement even though the patient was asked to do so and the patient was given the Notice of Privacy Practices*

☐ *Other:*_____

_____

Patient Label or
Patient Name:
MR#:

Account #:

*Date:*_____ *Time:*_____ *AM/PM*

*Signature:*_____
(Provider Representative)

*Print Name:*_____
(Provider Representative)

I certify that I have read the foregoing and received a copy thereof. I am the patient, the patient's legal representative, or I am otherwise authorized by the patient to sign the above and accept its terms on his/her behalf.

Date: _____ Time: _____ AM / PM

Signature: _____
(patient/legal representative)

If signed by someone other than patient, indicate relationship:

Print name:_____
(legal representative)

Signature: _____
(witness)

Print name: _____
(witness)

Original: Health Record
Copies: Patient (or whoever has signed the form)
Person financially responsible (if other than the patient or whoever signed the form)

Patient Label or
Patient Name:
MR#:

Account #:

CASA COLINA HOSPITAL AND CENTERS FOR HEALTHCARE
NOTICE OF PRIVACY PRACTICES: ACKNOWLEDGEMENT OF RECEIPT

By signing this form, you acknowledge receipt of the "Notice of Privacy Practices" of Casa Colina Hospital and Centers for Healthcare. Out "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 Practices." If we change our notice, you may obtain a copy of the revised notice by accessing our website at www.casacolina.org or contacting our organization at (909) 596-7733 ext. 3410.

If you have any questions about our "Notice of Privacy Practices," please contact: Debra Schultz, Privacy Officer at (909) 596-7733 ext. 3410.

I acknowledge receipt of the "Notice of Privacy Practices" of Casa Colina Hospital and Centers for Healthcare.

Date: _____ Time: _____ AM / PM

Signature: _____
(*patient/legal representative*)

If signed by someone other than patient, indicate relationship: _____

Print name: _____
(*legal representative*)

Nondiscrimination Policy

As a recipient of Federal financial assistance, Casa Colina Hospital and Centers for Healthcare does not exclude, deny benefits to, or otherwise discriminate against any person on the ground of race, color, national origin, disability, sex, sexual orientation, gender identity, religion, creed, or age in admission to, participation in, or receipt of the services and benefits under any of its programs and activities, and in staff and employee assignments to patients, whether carried out by Casa Colina Hospital and Centers for Healthcare directly or through a contractor or any other entity with which Casa Colina Hospital and Centers for Healthcare arranges to carry out its programs and activities.

This statement is in accordance with the provisions of Title VI of the Civil Rights Act of 1964 (nondiscrimination on the basis of race, color, national origin), Section 504 of the Rehabilitation Act of 1973 (nondiscrimination on the basis of disability), the Age Discrimination Act of 1975 (nondiscrimination on the basis of age), regulations of the U.S. Department of Health and Human Services issued pursuant to these three statutes at Title 45 Code of Federal Regulations Parts 80, 84, and 91.

Additionally, in accordance with Section 1557 of the Patient Protection and Affordable Care Act of 2010, 42 U.S.C. § 18116, Casa Colina Hospital and Centers for Healthcare does not exclude, deny benefits to, or otherwise discriminate against any person on the ground of sex (including gender identity) in admission to, participation in, or receipt of the services and benefits under any of its health programs and activities, and in staff and employee assignments, whether carried out by Casa Colina Hospital and Centers for Healthcare directly or through a contractor or any other entity with which Casa Colina Hospital and Centers for Healthcare arranges to carry out its programs and activities.

In case of questions, please contact:

1-909-596-7733, Ext. 6014, (TTY: 1-909-596-3646)

Effective Date: 2/15/16

NOTICE OF PRIVACY PRACTICES

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 the Privacy Officer at (909) 596-7733 EXT 3410.

For purposes of the remainder of this document, Casa Colina Hospital and Centers for Healthcare will be stated as “Casa Colina”.

WHO WILL FOLLOW THIS NOTICE

This notice describes Casa Colina’s practices and that of:

- Any health care professional authorized to enter information into your Casa Colina medical record.
- All departments and units of Casa Colina.
- Any member of a volunteer group we allow to help while you are in Casa Colina.
- All employees, staff and other Casa Colina personnel.

All Casa Colina entities, sites, and locations follow the same terms of this notice. In addition, these entities, sites, and locations may share medical information with each other for treatment, payment or health care 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 at Casa Colina. We need this record to provide you with the quality care and to comply with certain legal requirements. This notice applies to all of the record of your care generated by Casa Colina, whether made by Casa Colina personnel or your personal doctor. Your personal doctor may have different policies or notices regarding the doctor’s use and disclosure of your medical information created 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. 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 (with certain exceptions);
- 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 you some examples. Not every use or disclosure in a category will be listed. However, all of 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, therapists, technicians, health care students, or other Casa Colina personnel who are involved in taking care of you at Casa Colina. 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 the dietician if you have diabetes so that we can arrange for appropriate meals. Different departments of Casa Colina also may share medical information about you in order to coordinate the different things you need, such as prescriptions, lab work, or X-rays. We also may disclose medical information about you to people outside of Casa Colina who may be involved in your medical care after you leave Casa Colina, such as skilled nursing facilities, home health agencies, and 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 at Casa Colina may be billed 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 Casa Colina to your health care 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 Casa Colina who are involved in your care, to assist them in obtaining payment for services they provide to you. However we cannot disclose information to your health plan for payment purposes if you ask us not to and if you are paying for the services yourself.

FOR HEALTH CARE OPERATIONS

We may use and disclose medical information about you for health care operations. These uses and disclosures are necessary to run Casa Colina 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 Casa Colina patients to decide what additional services Casa Colina should offer, what services are not needed, and whether certain new treatments are effective. We may also disclose information to doctors, nurses, therapists, technicians, medical and healthcare students and other Casa Colina personnel for review and learning purposes. We may also combine the medical information we have with medical information from other healthcare facilities 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 ACTIVITES

We may use information about you, or disclose such information to the Casa Colina Foundation, to contact you in an effort to raise money for Casa Colina and its 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.

CASA COLINA DIRECTORY

We may include certain limited information about you in the Casa Colina directory while you are a patient or resident at Casa Colina. This information may include your name,

location in Casa Colina, 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 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 in Casa Colina 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.

TO INDIVIDUAL INVOLVED IN YOUR CARE OR PAYMENT FOR 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 in Casa Colina.

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 there is an emergent situation where you may become 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).

FOR 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. 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 Casa Colina.

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.

SPECIAL SITUATIONS

ORGAN AND TISSUE DONATION

We may release medical information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

MILITARY AND VETERANS

If you are a member of the armed forces, 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.

WORKERS' COMPENSATION

We may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

PUBLIC HEALTH ACTIVITIES

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 regarding 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 you have 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 ACTIVITES

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 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 the death of a person;
- About any criminal conduct at Casa Colina; 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 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 disclose medical information about you to the correctional instruction or law enforcement official. This disclosure 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 describes 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 primary 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 obtain a copy of medical information that may be used to make decisions about your care. Usually, this includes medical billing records, but may not include some mental health information.

To inspect and obtain a copy of medical information that may be used to make decisions about you, you must submit your request in writing to:

Privacy Officer
Casa Colina Hospital and Centers for Healthcare
255 E. Bonita Ave.
Pomona, CA 91767

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 obtain 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 Casa Colina 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 AMMEND

If you feel that 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 Casa Colina.

To request an amendment, your request must be made in writing and submitted to:

Privacy Officer
Casa Colina Hospital and Centers for Healthcare
255 E. Bonita Ave.
Pomona, CA 91767

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 entity that created the information is no longer available to make the amendment;
- Is not part of the medical information kept by or for Casa Colina;
- 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

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:

Privacy Officer
Casa Colina Hospital and Centers for Healthcare
255 E. Bonita Ave.
Pomona, CA 91767

Your request must state a time period which may not be longer than six years from the date of your request. Your request should indicate in what form you want the list (for example, on paper or electronically). The first list you request within a 12-month period will be free. For additional lists, we 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.

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 options. 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 to the extent that you request us to restrict disclosure 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 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:

Privacy Officer
Casa Colina Hospital and Centers for Healthcare
255 E. Bonita Ave.
Pomona, CA 91767

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:

Privacy Officer
Casa Colina Hospital and Centers for Healthcare
255 E. Bonita Ave.
Pomona, CA 91767

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 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.

You may obtain a copy of this notice at our website: www.casacolina.org

Paper copies of this notice are available from the Admission Departments or the Outpatient Registration areas.

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 various locations throughout Casa Colina. 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 Casa Colina 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 Casa Colina or with the Secretary of the U.S. Department of Health and Human Services. To file a complaint with Casa Colina, contact:

Privacy Officer
Casa Colina Hospital and Centers for Healthcare
255 E. Bonita Ave.
Pomona, CA 91767

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.

Patient Rights

As a patient of Casa Colina, you have the right to:

1. Considerate and respectful care, and to be made comfortable. You have the right to respect for your cultural, psychosocial, spiritual, and personal values, beliefs and preferences.

2. Have a family member (or other representative of your choosing) and your own physician notified promptly of your admission to the hospital.

3. Know the name of the licensed health care practitioner acting within the scope of his or her professional licensure and who has primary responsibility for coordinating your care, and the names and professional relationships of physicians and non-physicians who will see you.

4. Receive information about your health status, diagnosis, prognosis, course of treatment, prospects for recovery and outcomes of care (including unanticipated outcomes) in terms you can understand. You have the right to access your medical records. You will receive a separate "Notice of Privacy Practices" that explains your rights to access your records. You have the right to effective communication and to participate in the development and implementation of your plan of care. You have the right to participate in ethical questions that arise in the course of your care, including issues of conflict resolution, withholding resuscitative services, and forgoing or withdrawing life-sustaining treatment. You may request an Ethics consult by dialing extension 3018.

5. Make decisions regarding medical care, and receive as much information about any proposed treatment or procedure as you may need in order to give informed consent or to refuse a course of treatment. Except in emergencies, this information shall include a description of the procedure or treatment, the medically significant risks involved, alternate courses of treatment or non-treatment and the risks involved in each, and the name of the person who will carry out the procedure or treatment.

6. Request or refuse treatment, to the extent permitted by law. However, you do not have the right to demand inappropriate or medically unnecessary treatment or services. You have the right to leave the hospital even against the advice of members of the medical staff, to the extent permitted by law.

7. Be advised if the hospital/licensed health care practitioner acting within the scope of his or her professional licensure proposes to engage in or perform human experimentation affecting your care or treatment. You have the right to refuse to participate in such research projects.

8. Reasonable responses to any reasonable requests made for service.

9. Appropriate assessment and management of your pain, information about pain, pain relief measures and to participate in pain management decisions. You may request or reject the use of any or all modalities to relieve pain, including opiate medication, if you suffer from severe chronic intractable pain. The doctor may refuse to prescribe the opiate medication, but if so, must inform you that there are physicians who specialize in the treatment of pain with methods that include the use of opiates.

10. Formulate advance directives. This includes designating a decision maker if you become incapable of understanding a proposed treatment or become unable to communicate your wishes regarding care. Hospital staff and practitioners who provide care in the hospital shall comply with these directives. All patients' rights apply to the person who has legal responsibility to make decisions regarding medical care on your behalf.

11. Have personal privacy respected. Case discussion, consultation, examination and treatment are confidential and should be conducted discreetly. You have the right to be told the reason for the presence of any individual. You have the right to have visitors leave prior to an examination and when treatment issues are being discussed. Privacy curtains will be used in semi-private rooms.

12. Confidential treatment of all communications and records pertaining to your care and stay in the hospital. You will receive a separate "Notice of Privacy Practices" that explains your privacy rights in detail and how we may use and disclose your protected health information.

13. Receive care in a safe setting, free from mental, physical, sexual or verbal abuse and neglect, exploitation or harassment. You have the right to access protective and advocacy services including notifying government agencies of neglect or abuse.

14. Be free from restraints and seclusion of any form used as a means of coercion, discipline, convenience or retaliation by staff.

15. Receive reasonable continuity of care and to know in advance the time and location of appointments as well as the identity of the persons providing the care.

16. Be informed by the physician, or a delegate of the physician, of continuing health care requirements and options following discharge from the hospital. You have the right to be involved in the development and implementation of your discharge plan. Upon your request, a friend or family member may be provided this information also.

17. Know which hospital rules and policies apply to your conduct while a patient.

18. Designate a support person as well as visitors of your choosing, if you have decision-making capacity, whether or not the visitor is related by blood, marriage, or registered domestic partner status, unless:

- No visitors are allowed.
- The facility reasonably determines that the presence of a particular visitor would endanger the health or safety of a patient, a member of the health facility staff, or other visitor to the health facility, or would significantly disrupt the operations of the facility.
- You have told the health facility staff that you no longer want a particular person to visit.

However, a health facility may establish reasonable restrictions upon visitation, including restrictions upon the hours of visitation and number of visitors. The health facility must inform you (or your support person, where appropriate) of your visitation rights, including any clinical restrictions or limitations. The health facility is not permitted to restrict, limit, or otherwise deny visitation privileges on the basis of race, color, national origin, religion, sex, gender identity, sexual orientation, or disability.

19. Have your wishes considered, if you lack decision-making capacity, for the purposes of determining who may visit. The method of that consideration will comply with federal law and be disclosed in the hospital policy on visitation. At a minimum, the hospital shall include any persons living in your household and any support person pursuant to federal law.

20. Examine and receive an explanation of the hospital's bill regardless of the source of payment.

21. Exercise these rights without regard to, and be free of discrimination on the basis of, sex, economic status, educational background, race, color, religion, ancestry, national origin, sexual orientation, gender identity/expression, disability, medical condition, marital status, age, registered domestic partner status, genetic information, citizenship, primary language, immigration status (except as required by federal law) or the source of payment for care.

22. File a grievance. If you want to file a grievance with this hospital, you may do so by writing or by calling Hospital Administration, Casa Colina Hospital and Centers for Healthcare, 255 East Bonita Avenue, PO Box 6001, Pomona, CA 91769-6001; 909/596-7733, ext. 3000.

The grievance committee will review each grievance and provide you with a written response within 7 (seven) days of receipt. The written response will contain the name of a person to contact at the hospital, the steps taken to investigate the grievance, the results of the grievance process, and the date of completion of the grievance process.

Concerns regarding quality of care or premature discharge for Medicare patients should be referred to the Quality Improvement Organization (QIO) as follows: Livanta, 9090 Junction Drive, Suite 10, Annapolis Junction, MD 20701 Attn: Beneficiary Complaints; 877/588-1123; www.BFCCQIOAREA5.com. Non-Medicare patients would need to contact their private insurance's customer service department.

23. File a complaint with the California Department of Public Health regardless of whether you use the hospital's grievance process. The California Department of Public Health's phone number and address is: California Department of Public Health Services, Health Facilities Inspection/LACounty Acute & Ancillary Unit, 3400 Aerojet Avenue, Suite 323, El Monte, CA 91731; 800/228-1019 or 626/312-1104.

24. Submit written complaints related to the professional competence or professional conduct of a physician, Doctor of Osteopathy, or doctor of podiatry. These complaints should be forwarded to the only authority in the State of California that may take disciplinary action against the provider's license. The applicable State Boards are as follows:

Regarding Physicians or Podiatrists:
Medical Board of California, Central Complaint Unit
2005 Evergreen Street, Suite 1200
Sacramento, CA 95815
800/633-2322
Online: www.mbc.ca.gov/consumers/complaints

Regarding a Psychologist, Psychological Assistant, or Registered Psychologist:
Board of Psychology
1625 North Market Street, Suite N-215
Sacramento, CA 95834
866/503-3221
Online: https://www.psychology.ca.gov/forms_pubs/form.pdf

Regarding Doctors of Osteopathy:
Osteopathic Medical Board of California
1300 National Drive, Suite 150
Sacramento, CA 95834-1991
916/928-8390
Online: www.ombc.ca.gov/forms_pubs/

Department of Fair Employment and Housing
www.dfeh.ca.gov, 800/884-1684 or 800/700-2320 (TTY)
2218 Kausen Dr., #100, Elk Grove, CA 95758

25. If you have concerns about patient care and safety that cannot be resolved through the hospital, you are encouraged by the hospital to contact the Joint Commission Office of Quality and Patient Safety either by faxing 630/792-5636 or visiting https://www.jointcommission.org/resources/patient-safety-topics/report-a-patient-safety-event. You can also write to: The Joint Commission, Office of Quality and Patient Safety, One Renaissance Boulevard, Oakbrook Terrace, IL 60181.

This Patient Rights document incorporates the requirements of The Joint Commission; Title 22, California Code of Regulations, Section 70707; Health and Safety Code Sections 1262.6, 1288.4, and 124960; and 42 C.F.R. Section 482.13 (Medicare Conditions of Participation).