Patient Registration Form

Welcome to Share Ourselves!
We are happy you have chosen us for your care. To register, please fill out as much of this form as you can. Some of these items help us ensure we are meeting the needs of the people we serve. Please tell us if you have any questions, or if you need help filling out this form.

Legal Name

First: _____ Middle: _____ Last: _____

Preferred Name

First: _____ Middle: _____ Last: _____

Preferred pronouns:

☐ She/her/hers ☐ They/them/theirs ☐ He/him/his
☐ Use preferred name only ☐ Decline to answer ☐ Other:_____

Birth

Date of birth (month/day/year): _____ Age: _____

Social Security Number (if you have one): _____

Individual Taxpayer Identification Number (if you have one): _____

Sex assigned at birth: ☐ Female ☐ Male ☐ Unknown ☐ Intersex
☐ Choose not to say ☐ Not listed on birth certificate

Address

Street Address: _____ Unit/Space/Apt. #: _____

City: _____ State: _____ Zip Code: _____

Contact Information

Best phone number: _____ Can we leave messages?: ☐ Yes ☐ No

Is this phone number: ☐ Work ☐ Home ☐ Mobile ☐
Other_____

Share Ourselves

Can we leave messages?: ☐ Yes ☐ No

Other phone number: _____

Is this phone number: ☐ Work ☐ Home ☐ Mobile ☐ Other _____

Preferred language: ☐ English ☐ Spanish ☐ Other

_____

Do you need translation help?: ☐ Yes ☐ No

How can we reach you? Choose all that apply:

☐ Telephone ☐ Text ☐ In writing ☐ Patient portal ☐ Email

If you choose **email** or **patient portal**, please list your email address:

_____

Marital Status

Marital status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

☐ Domestic partnership ☐ Significant other

Emergency Contact

For patients under 18, this must be different from the parent(s) or legal guardian(s) below.

First name: _____ Last name: _____

Relationship: _____ Phone number: _____

Is this phone number: ☐ Work ☐ Home ☐ Mobile ☐ Other_____

For Patients Under 18: Parent(s) or Legal Guardian(s)

☐ Mother ***or***

☐ Legal guardian 1

_____
Relationship

_____ _____
First name Last name

_____ _____
Date of birth Social Security Number or Individual Taxpayer Identification number

Street address: _____ Unit/Space/Apt. #: _____

City: _____ State: _____ Zip code: _____

Best phone number: _____ Can we leave messages?: ☐ Yes ☐ No

Is this phone number: ☐ Work ☐ Home ☐ Mobile ☐ Other_____

Other phone number: _____ Can we leave messages?: ☐ Yes ☐ No

Is this phone number: ☐ Work ☐ Home ☐ Mobile ☐ Other_____

☐ Father ***or***

☐ Legal guardian 2

_____
Relationship

_____ _____
First name Last name

_____ _____
Date of birth Social Security Number or Individual Taxpayer Identification number

Street address: _____ Unit/Space/Apt. #: _____

City: _____ State: _____ Zip code: _____

Best phone number: _____ Can we leave messages?: ☐ Yes ☐ No

Is this phone number: ☐ Work ☐ Home ☐ Mobile ☐ Other_____

Other phone number: _____ Can we leave messages?: ☐ Yes ☐ No

Is this phone number: ☐ Work ☐ Home ☐ Mobile ☐ Other_____

Because Share Ourselves is a Federally Qualified Health Center (FQHC), we must collect the information below. This helps us provide health care and sliding fee discounts to patients who qualify. We will keep your answers private.

Household Information

How many people live in your home?
(Include only yourself and family members you are financially responsible for.) _____

What is the total combined income of the family members included in the last question? _____
☐ Monthly ☐ Yearly

Would you like to know if you are eligible for our sliding fee discount program? ☐ Yes ☐ No

Insurance Information

Tell us about the patient's health insurance. Please provide the patient's insurance card at the time of check in.

Does the patient's or parent's employer offer medical or dental insurance?
☐ Yes ☐ No

Has the patient ever applied for any medical or dental insurance?
☐ Yes ☐ No

If yes, what has the patient applied for?
☐ Medi-Cal ☐ MSN
☐ Emergency Medi-Cal
☐ Medicare
☐ Other: _____

What insurance does the patient have now? _____ Health plan name _____ Member ID

Work Information

Work status: ☐ Full time ☐ Part time ☐ Full time student ☐ Part time student
☐ Unemployed ☐ Retired ☐Disabled ☐ Under 18

Job: _____

Does anyone in the home do farm work?
☐ Yes ☐ No

If yes, check all that apply:
☐ Migratory farm worker (moves to follow farm work)
☐ Seasonal farm worker (main job is farm work, but does not move to follow it)

Is the patient a veteran? ☐ Yes ☐ No

More Information

Gender Identity

☐ Female ☐ Male ☐ Transgender female (male to female)
☐ Transgender male (female to male) ☐ Choose not to say
☐ Other (specify): _____

Sexual Orientation

☐ Straight (heterosexual) ☐ Bisexual ☐ Gay ☐ Lesbian
☐ Pansexual ☐ Choose not to say
☐ Other (specify): _____

Ethnicity

☐ Cuban ☐ Mexican/Mexican-American/Chicano(a)
☐ Mulitple Hispanic/Latino(a)/Spanish Origins
☐ Non-Hispanic/Non-Latino(a) ☐ Puerto Rican
☐ Another Hispanic/Latino(a)/Spanish Origin ☐ Unknown
☐ Choose not to say

Race

☐ Alaskan Native ☐ American Indian ☐ Asian Indian
☐ Black/African American ☐ Chinese ☐ Filipino ☐ Korean
☐ Guamanian or Chamorro ☐ Japanese ☐ Native Hawaiian
☐ Other Asian ☐ Other Pacific Islander ☐ Vietnamese
☐ Samoan ☐ White ☐ Unknown ☐ Choose not to say
☐ Other (specify): _____

Highest Level of Education Completed

☐ Does not apply ☐ Did not complete high school
☐ High school ☐ Some college/Associate's degree
☐ Bachelor's degree or higher

Living Situation

☐ Homeless shelter ☐ Street ☐ Transitional housing
☐ Doubling up ☐ Permanent supportive housing
☐ Not homeless/not receiving assistance ☐ Other

How did you hear about us? Check all that apply.

☐ Insurance assigned me ☐ Community event/fair
☐ Family or friend ☐ Share Ourselves patient referral
☐ Hospital/doctor's office ☐ Share Ourselves employee
☐ El Sol Academy/student/family ☐ Automated phone invite
☐ Share Ourselves called me ☐ Ad ☐ Brochure ☐ 211
☐ Hoag Family Resource Center ☐ Social media
☐ Share Ourselves community event ☐ Yelp ☐ Google ad
☐ Share Ourselves website
☐ Other (specify):
_____

General Consent for Treatment

Share Ourselves needs your permission to give reasonable and needed exams, tests, and treatments. This consent will stay in effect and will continue to apply to future services until you revoke it in writing. Please read the statements below carefully.

I understand:

- This General Consent for Treatment applies to:
  - All Share Ourselves care facilities, divisions, programs, departments, and units.
  - General services meant to diagnose health problems.
  - Routine procedures (like lab work and EKGs) meant to treat health problems.
  - Other non-invasive procedures deemed needed for my care or in my best interest.
- Sometimes, Share Ourselves may ask me to sign more consent forms (called "informed consents") if non-routine or more invasive procedures are advised as part of my treatment.
- Share Ourselves can't advise any treatment for me until I've been assessed by a licensed healthcare provider.
- I have the right to ask questions about anything I don't understand as it pertains to my health care. I have the right to discuss the purpose, potential risks, and benefits of any test or treatment with my provider.
- Rarely, my provider may ask to take photos as part of my care (such as when I have a rash or wound). These photos are taken in a secure way. They are stored in a secure way in my electronic health record.
- The practice of medicine is not an exact science. Share Ourselves can't make any guarantee or promise to me about the results of any procedures or treatments.
- I may get care from various types of providers. These include, but aren't limited to, medical doctors, doctors of osteopathy, and nurse practitioners.
- Share Ourselves is a learning place. Sometimes, residents, interns, and other types of students may be involved in my care. All such staff are appropriately educated, licensed, or certified. Suitable Share Ourselves providers supervise students. If I don't wish to be treated by residents, interns, or other types of students, I have the right to decline their services at any time.
- Other Share Ourselves staff may help with my care at the direction of my care provider. These include, but aren't limited to, nurses, medical assistants, and medical scribes.
- I am free to refuse individual treatments at any time.

By signing below, I confirm I have read, fully understand, and agree to the information above. Any questions I had about the content of this document have been answered.

Who is signing this form? Indicate with a ✓ mark:

☐ Patient ☐ Parent/Legal Guardian (if patient is a minor) ☐ Authorized Representative

_____	_____	_____
Print Name	Signature	Date

For Office Use Only

Verbal Consent

For use only if the patient and/or the patient's authorized representative requires assistance reading this form.

This document was read on _____ to the patient mentioned above (or to the patient's authorized representative) by:

_____	_____	_____
Print Name	Signature	Date

WHAT IF I CHANGE MY MIND?

You can change or cancel your advance directive at any time as long as you can communicate your wishes. To change the person you want to make your healthcare decisions, you must sign a statement or tell the doctor in charge of your care.

WHAT HAPPENS WHEN SOMEONE ELSE MAKES DECISIONS ABOUT MY TREATMENT?

The same rules apply to anyone who makes healthcare decisions on your behalf – a healthcare agent, a surrogate whose name you gave to your doctor, or a person appointed by a court to make decisions for you. All are required to follow your **Health Care Instructions** or, if none, your general wishes about treatment, including stopping treatment. If your treatment wishes are not known, the surrogate must try to determine what is in your best interest. The people providing your health care must follow the decisions of your agent or surrogate unless a requested treatment would be bad medical practice or ineffective in helping you. If this causes disagreement that cannot be worked out, the provider must make a reasonable effort to find another healthcare provider to take over your treatment.

WILL I STILL BE TREATED IF I DON'T MAKE AN ADVANCE DIRECTIVE?

Absolutely. You will still get medical treatment. We just want you to know that if you become too sick to make decisions, someone else will have to make them for you. Remember that:

- A **POWER OF ATTORNEY FOR HEALTH CARE** lets you name an agent to make decisions for you. Your agent can make most medical decisions – not just those about life sustaining treatment – when you can't speak for yourself. You can also let your agent make decisions earlier, if you wish.

- YOU CAN CREATE AN **INDIVIDUAL HEALTHCARE INSTRUCTION** by writing down your wishes about health care or by talking with your doctor and asking the doctor to record your wishes in your medical file. If you know when you would or would not want certain types of treatment, an **Instruction** provides a good way to make your wishes clear to your doctor and to anyone else who may be involved in deciding about treatment on your behalf.

- THESE TWO TYPES OF **ADVANCE HEALTHCARE DIRECTIVES** may be used together or separately.

To implement Public Law 101-508, the California Consortium on Patient Self-Determination prepared this brochure in 1991; it was revised in 2000 by the California Department of Health Services, with input from members of the consortium and other interested parties, to reflect changes in state law.

HOW CAN I GET MORE INFORMATION ABOUT MAKING AN ADVANCE DIRECTIVE?

Ask your doctor, nurse, social worker, or healthcare provider to get more information for you. You can have a lawyer write an advance directive for you, or you can complete an advance directive by filling in the blanks on a form.

PUB 325 (12/16)

STATE OF CALIFORNIA

HEALTH AND HUMAN SERVICES AGENCY

DEPARTMENT OF SOCIAL SERVICES

Flex your POWER℠

CDSS CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

Your Right To Make Decisions About Medical Treatment

- This brochure explains your right to make healthcare decisions and how you can plan now for your medical care if you are unable to speak for yourself in the future.

- A federal law requires us to give you this information. We hope this information will help increase your control over your medical treatment.

WHO DECIDES ABOUT MY TREATMENT?

Your doctors will give you information and advice about treatment. You have the right to choose. You can say "Yes" to treatments you want. You can say "No" to any treatment that you don't want – even if the treatment might keep you alive longer.

HOW DO I KNOW WHAT I WANT?

Your doctor must tell you about your medical condition and about what different treatments and pain management alternatives can do for you. Many treatments have "side effects." Your doctor must offer you information about problems that medical treatment is likely to cause you.

Often, more than one treatment might help you – and people have different ideas about which is best. Your doctor can tell you which treatments are available to you, but your doctor can't choose for you. That choice is yours to make and depends on what is important to you.

CAN OTHER PEOPLE HELP WITH MY DECISIONS?

Yes. Patients often turn to their relatives and close friends for help in making medical decisions. These people can help you think about the choices you face. You can ask the doctors and nurses to talk with your relatives and friends. They can ask the doctors and nurses questions for you.

CAN I CHOOSE A RELATIVE OR FRIEND TO MAKE HEALTHCARE DECISIONS FOR ME?

Yes. You may tell your doctor that you want someone else to make healthcare decisions for you. Ask the doctor to list that person as your healthcare"surrogate" in your medical record. The surrogate's control over your medical decisions is effective only during treatment for your current illness or injury or, if you are in a medical facility, until you leave the facility.

WHAT IF I BECOME TOO SICK TO MAKE MY OWN HEALTHCARE DECISIONS?

If you haven't named a surrogate, your doctor will ask your closest available relative or friend to help decide what is best for you. Most of the time that works. But sometimes everyone doesn't agree about what to do. That's why it is helpful if you can say in advance what you want to happen if you can't speak for yourself.

DO I HAVE TO WAIT UNTIL I AM SICK TO EXPRESS MY WISHES ABOUT HEALTH CARE?

No. In fact, it is better to choose before you get very sick or have to go into a hospital, nursing home, or other healthcare facility. You can use an **Advance Health Care Directive** to say *who* you want to speak for you and *what* kind of treatments you want. These documents are called "advance" because you prepare one before healthcare decisions need to be made. They are called "directives" because they state who will speak on your behalf and what should be done.

In California, the part of an advance directive you can use to appoint an agent to make healthcare decisions is called a **Power of Attorney For Health Care**. The part where you can express what you want done is called an **Individual Health Care Instruction**.

WHO CAN MAKE AN ADVANCE DIRECTIVE?

You can if you are 18 years or older and are capable of making your own medical decisions. You do not need a lawyer.

WHO CAN I NAME AS MY AGENT?

You can choose an adult relative or any other person you trust to speak for you when medical decisions must be made.

WHEN DOES MY AGENT BEGIN MAKING MY MEDICAL DECISIONS?

Usually, a healthcare agent will make decisions only after you lose the ability to make them yourself. But, if you wish, you can state in the **Power of Attorney for Health Care** that you want the agent to begin making decisions immediately.

HOW DOES MY AGENT KNOW WHAT I WOULD WANT?

After you choose your agent, talk to that person about what you want. Sometimes treatment decisions are hard to make, and it truly helps if your agent knows what you want. You can also write your wishes down in your advance directive.

WHAT IF I DON'T WANT TO NAME AN AGENT?

You can still write out your wishes in your advance directive, without naming an agent. You can say that you want to have your life continued as long as possible. Or you can say that you would not want treatment to continue your life. Also, you can express your wishes about the use of pain relief or any other type of medical treatment.

Even if you have not filled out a written **Individual Health Care Instruction**, you can discuss your wishes with your doctor, and ask your doctor to list those wishes in your medical record. Or you can discuss your wishes with your family members or friends. But it will probably be easier to follow your wishes if you write them down.

California Advance Health Care Directive

This form lets you have a say about how you want to be cared for if you cannot speak for yourself.

This form has 3 parts:

Part 1 Choose a medical decision maker, Page 3

A medical decision maker is a person who can make health care decisions for you if you are not able to make them yourself.

This person will be your advocate.

They are also called a health care agent, proxy, or surrogate.

Part 2 Make your own health care choices, Page 7

This form lets you choose the kind of health care you want. This way, those who care for you will not have to guess what you want if you are not able to tell them yourself.

Part 3 Sign the form, Page 13

The form must be signed before it can be used.

You can fill out Part 1, Part 2, or both.

Fill out only the parts you want. Always sign the form in Part 3.

2 witnesses need to sign on Page 14, or a notary on Page 15.

Your Name

Developed by PREPARE™ for your care

www.prepareforyourcare.org

This is a legal form that lets you have a voice in your health care.

It will let your family, friends, and medical providers know how you want to be cared for if you cannot speak for yourself.

What should I do with this form?

- Please share this form with your family, friends, and medical providers.
- Please make sure copies of this form are placed in your medical record at all the places you get care.

What if I have questions about the form?

- It is OK to skip any part of this form if you have questions or do not want to answer.
- Ask your doctors, nurses, social workers, family, or friends to help.
- Lawyers can help too. This form does not give legal advice.

What if I want to make health care choices that are not on this form?

- On Page 12, you can write down anything else that is important to you.

When should I fill out this form again?

- If you change your mind about your health care choices
- If your health changes
- If your medical decision maker changes

If your spouse is your decision maker, and you divorce, that person will no longer be your decision maker.

Give the new form to your medical decision maker and medical providers.

Destroy old forms.

Share this form and your choices with your family, friends, and medical providers.

Part 1 Choose your medical decision maker

Your medical decision maker can make health care decisions for you if you are not able to make them yourself.

A good medical decision maker is a family member or friend who:

- is 18 years of age or older
- can talk to you about your wishes
- can be there for you when you need them
- you trust to follow your wishes and do what is best for you
- you trust to know your medical information
- is not afraid to ask doctors questions and speak up about your wishes

Legally, your decision maker cannot be your doctor or someone who works at your hospital or clinic, unless they are a family member.

What will happen if I do not choose a medical decision maker?

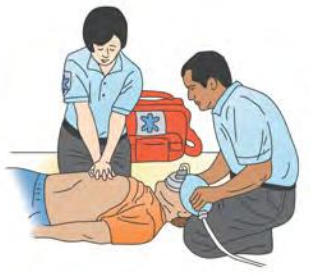
If you are not able to make your own decisions, your doctors will turn to family and friends or a judge to make decisions for you. This person may not know what you want.

If you are not able, your medical decision maker can choose these things for you:

- doctors, nurses, social workers, caregivers
- hospitals, clinics, nursing homes
- medications, tests, or treatments
- who can look at your medical information
- what happens to your body and organs after you die

Here are more decisions your medical decision maker can make:

Start or stop life support or medical treatments, such as:

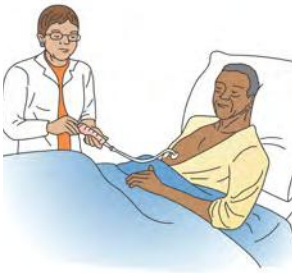


- **CPR or cardiopulmonary resuscitation**
  cardio = heart • pulmonary = lungs • resuscitation = try to bring back

  This may involve:
  - pressing hard on your chest to try to keep your blood pumping
  - electrical shocks to try to jump start your heart
  - medicines in your veins

- **Breathing machine or ventilator**
  The machine pumps air into your lungs and tries to breathe for you. You are not able to talk when you are on the machine.

- **Dialysis**
  A machine that tries to clean your blood if your kidneys stop working.

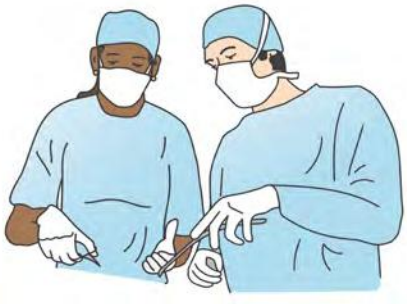


- **Feeding Tube**
  A tube used to try to feed you if you cannot swallow. The tube can be placed through your nose down into your throat and stomach. It can also be placed by surgery into your stomach.

- **Blood and water transfusions (IV)**
  To put blood and water into your body.

- **Surgery**

- **Medicines**



End of life decisions your medical decision maker can make:

- call in a religious or spiritual leader
- decide if you die at home or in the hospital
- decide about autopsy or organ donation
- decide about burial or cremation

Your Name

By signing this form, you allow your medical decision maker to:

- agree to, refuse, or withdraw any life support or medical treatment if you are not able to speak for yourself
- decide what happens to your body after you die, such as funeral plans and organ donation

If there are decisions you do not want them to make, write them here:

When can my medical decision maker make decisions for me?

- ☐ ONLY after I am not able to make my own decisions
- ◯ NOW, right after I sign this form

If you want, you can write why you feel this way.

Write the name of your medical decision maker.

#1: I want this person to make my medical decisions if I am not able to make my own:

first name | last name

phone #1 | phone #2 | relationship

address | city | state | zip code

#2: If the first person cannot do it, then I want this person to make my medical decisions:

first name | last name

phone #1 | phone #2 | relationship

address | city | state | zip code

Your Name

Why did you choose your medical decision maker?

If you want, you can write why you chose your #1 and #2 decision makers.

Write down anyone you would NOT want to help make medical decisions for you.

How strictly do you want your medical decision maker to follow your wishes if you are not able to speak for yourself?

Flexibility allows your decision maker to change your prior decisions if doctors think something else is better for you at that time.

Prior decisions may be wishes you wrote down or talked about with your medical decision maker. You can write your wishes in Part 2 of this form.

Check the one choice you most agree with.

- ☐ **Total Flexibility:** It is OK for my decision maker to change any of my medical decisions if my doctors think it is best for me at that time.
- ◯ **Some Flexibility:** It is OK for my decision maker to change some of my decisions if the doctors think it is best. But, these wishes I NEVER want changed:

- ◯ **No Flexibility:** I want my decision maker to follow my medical wishes exactly. It is NOT OK to change my decisions, even if the doctors recommend it.

If you want, you can write why you feel this way.

To make your own health care choices, go to Part 2 on Page 7. If you are done, you must sign this form on Page 13.

Please share your wishes with your family, friends, and medical providers.

Part 2 Make your own health care choices

Fill out only the questions you want.

How do you prefer to make medical decisions?

Some people prefer to make their own medical decisions. Some people prefer input from others (family, friends, and medical providers) before they make a decision. And, some people prefer other people make decisions for them.

Please note: Medical providers cannot make decisions for you. They can only give information to help with decision making.

How do you prefer to make medical decisions?

- ☐ I prefer to make medical decisions on my own without input from others.
- ☐ I prefer to make medical decisions only after input from others.
- ☐ I prefer to have other people make medical decisions for me.

If you want, you can write why you feel this way, and who you want input from.

What matters most in life? Quality of life differs for each person.

What is most important in your life? Check as many as you want.

- ☐ Your family or friends _____
- ☐ Your pets _____
- ☐ Hobbies, such as gardening, hiking, and cooking
  Your hobbies _____
- ☐ Working or volunteering _____
- ☐ Caring for yourself and being independent
- ☐ Not being a burden on your family
- ☐ Religion or spirituality: Your religion _____
- ☐ Something else _____

What brings your life joy? What are you most looking forward to in life?

Your Name

What matters most for your medical care? This differs for each person.

For some people, the main goal is to be kept alive as long as possible even if:

- They have to be kept alive on machines and are suffering
- They are too sick to talk to their family and friends

For other people, the main goal is to focus on quality of life and being comfortable.

- These people would prefer a natural death, and not be kept alive on machines

Other people are somewhere in between. **What is important to you?**

Your goals may differ today in your current health than at the end of life.

TODAY, IN YOUR CURRENT HEALTH

Check one choice along this line to show how you feel today, in your current health.

My main goal is to live as long as possible, no matter what.

Equally important

My main goal is to focus on quality of life and being comfortable.

If you want, you can write why you feel this way.

AT THE END OF LIFE

Check one choice along this line to show how you would feel if you were so sick that you may die soon.

My main goal is to live as long as possible, no matter what.

Equally important

My main goal is to focus on quality of life and being comfortable.

If you want, you can write why you feel this way.

Your Name

Quality of life differs for each person at the end of life. What would be most important to you?

AT THE END OF LIFE

Some people are willing to live through a lot for a chance of living longer.

Other people know that certain things would be very hard on their quality of life.

- Those things may make them want to focus on comfort rather than trying to live as long as possible.

At the end of life, which of these things would be very hard on your quality of life?
Check as many as you want.

- ☐ Being in a coma and not able to wake up or talk to my family and friends
- ☐ Not being able to live without being hooked up to machines
- ☐ Not being able to think for myself, such as severe dementia
- ☐ Not being able to feed, bathe, or take care of myself
- ☐ Not being able to live on my own, such as in a nursing home
- ☐ Having constant, severe pain or discomfort
- ☐ Something else _____

- ☐ **OR**, I am willing to live through all of these things for a chance of living longer.

If you want, you can write why you feel this way.

What experiences have you had with serious illness or with someone close to you who was very sick or dying?

- If you want, you can write down what went well or did not go well, and why.

If you were dying, where would you want to be?

☐ at home ☐ in the hospital ☐ either ☐ I am not sure

What else would be important, such as food, music, pets, or people you want around you?

Your Name

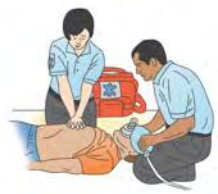
How do you balance quality of life with medical care?

Sometimes illness and the treatments used to try to help people live longer can cause pain, side effects, and the inability to care for yourself.

Please read this whole page before making a choice.

AT THE END OF LIFE, some people are willing to live through a lot for a chance of living longer. Other people know that certain things would be very hard on their quality of life.

Life support treatment can be CPR, a breathing machine, feeding tubes, dialysis, or transfusions.



Check the one choice you most agree with.

If you were so sick that you may die soon, what would you prefer?

- ☐ **Try all life support treatments** that my doctors think might help. I want to **stay on life support** treatments even if there is little hope of getting better or living a life I value.

- ☐ Do a **trial of life support treatments** that my doctors think might help. But, I **DO NOT want to stay on life support** treatments if the treatments do not work and there is little hope of getting better or living a life I value.

- ☐ **I do not want life support treatments**, and I want to focus on being comfortable. I prefer to have a **natural death**.

What else should your medical providers and decision maker know about this choice? Or, why did you choose this option?

Your Name

Your decision maker may be asked about organ donation and autopsy after you die. Please tell us your wishes.

ORGAN DONATION

Some people decide to donate their organs or body parts.
What do you prefer?

- ☐ I **want** to donate my organs or body parts.

  Which organ or body part do you want to donate?

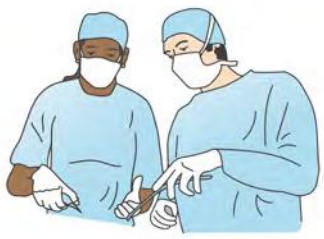
  - ☐ Any organ or body part
  - ☐ Only _____

- ☐ I **do not** want to donate my organs or body parts.

What else should your medical providers and medical decision maker know about donating your organs or body parts?

AUTOPSY

An autopsy can be done after death to find out why someone died.
It is done by surgery. It can take a few days.



- ☐ I **want** an autopsy.
- ☐ I **do not** want an autopsy.
- ☐ I **only** want an autopsy if there are questions about my death.

FUNERAL OR BURIAL WISHES

What should your medical providers and decision maker know about how you want your body to be treated after you die, and your funeral or burial wishes?

- Do you have religious or spiritual wishes?
- Do you have funeral or burial wishes?

Your Name

What else should your medical providers and medical decision maker know about you and your choices for medical care?

OPTIONAL: How do you prefer to get medical information?

Some people may want to know all of their medical information. Other people may not.

If you had a serious illness, would you want your doctors and medical providers to tell you how sick you are or how long you may have to live?

- ☐ Yes, I would want to know this information.
- ◯ No, I would not want to know. Please talk with my decision maker instead.

If you want, you can write why you feel this way.

* Talk to your medical providers so they know how you want to get information.

Your Name

Part 3 Sign the form

Before this form can be used, you must:

- sign this form if you are 18 years of age or older
- have two witnesses or a notary sign the form

Sign your name and write the date.

sign your name _____ today's date _____

print your first name _____ print your last name _____ date of birth _____

address _____ city _____ state _____ zip code _____

Witnesses or Notary

Before this form can be used, you must have 2 witnesses or a notary sign the form. The job of a notary is to make sure it is you signing the form.

Your witnesses must:

- be 18 years of age or older
- know you
- agree that it was you that signed this form

Your witnesses cannot:

- be your medical decision maker
- be your health care provider
- work for your health care provider
- work at the place that you live (if you live in a nursing home go to Page 15)

Also, one witness cannot:

- be related to you in any way
- benefit financially (get any money or property) after you die

Witnesses need to sign their names on Page 14.
If you do not have witnesses, a notary must sign on Page 15.

Have your witnesses sign their names and write the date.

By signing, I promise that _____ signed this form.
(the person named on Page 13)

They were thinking clearly and were not forced to sign it.

I also promise that:

- I know this person or they can prove who they are
- I am 18 years of age or older
- I am not their medical decision maker
- I am not their health care provider
- I do not work for their health care provider
- I do not work where they live

One witness must also promise that:

- I am not related to them by blood, marriage, or adoption
- I will not benefit financially (get any money or property) after they die

Witness #1

_____ _____
sign your name date

_____ _____
print your first name print your last name

_____ _____ _____ _____
address city state zip code

Witness #2

_____ _____
sign your name date

_____ _____
print your first name print your last name

_____ _____ _____ _____
address city state zip code

You are now done with this form.

Share this form with your family, friends, and medical providers. Talk with them about your medical wishes. To learn more go to www.prepareforyourcare.org

Developed by PREPARE™ for your care

Notary Public: Take this form to a notary public ONLY if two witnesses have not signed this form. Bring photo ID (driver's license, passport, etc.).

CERTIFICATE OF ACKNOWLEDGEMENT OF NOTARY PUBLIC

A Notary Public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

State of California County of _____

On _____ (Date) before me, _____ (Here insert name and title of the officer) , personally appeared _____ (Names(s) of Signer(s))

who proved to me the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct. WITNESS my hand and official seal.

Signature _____ (Signature of Notary Public)

Description of Attached Document

Title or type of document: _____

Date: _____ Number of pages: _____

Capacity(ies) Claimed by Signer(s)

Signer's Name: _____

○ Individual
○ Guardian or conservator
○ Other _____

(Notary Seal)

For California Nursing Home Residents ONLY

Give this form to your nursing home director ONLY if you live in a nursing home. California law requires nursing home residents to have the nursing home ombudsman as a witness of advance directives.

STATEMENT OF THE PATIENT ADVOCATE OR OMBUDSMAN

"I declare under penalty of perjury under the laws of California that I am a patient advocate or ombudsman as designated by the State Department of Aging and that I am serving as a witness as required by Section 4675 of the Probate Code."

sign your name _____ date _____

print your first name _____ print your last name _____

address _____ city _____ state _____ zip code _____

Paying for Services — Agreement

This document explains the payment policy for Share Ourselves services. Please read it carefully. **Share Ourselves will not deny any patient access to our services based on inability to pay.**

Paying for Services

You must pay all fees for the Share Ourselves services you receive. These fees include co-payments, deductibles, and bills that are past due. These fees are due at the time of service. By signing below, you agree that:

- You and your provider decide which Share Ourselves services you need.
- You will pay for the Share Ourselves services you receive.

Questions About Your Account

If you have questions about bills, payments, or other issues with your account, please contact the Share Ourselves billing company:

- OCHIN Billing Services: (833) 561-1986

Trouble Paying for Services

If you have concerns about your ability to pay for your services, please contact Share Ourselves' Billing Department right away. Share Ourselves has an established sliding fee schedule for which you may qualify.

- Share Ourselves Billing Department: (949) 536-3979

You might get a Share Ourselves bill by email or on paper. The bill will list any Share Ourselves services you received.

If you get a bill from Share Ourselves, you must pay it within 30 days. If we don't get your payment within 30 days, we will send you a reminder notice.

To pay a bill that is past due, call:

- OCHIN Billing Services: (833) 561-1986
- Or visit your local Share Ourselves clinic

If You Have Insurance

If you have health insurance, we want to help you get the most from it. But to do this, we need your help:

- **Your Duty.** You must find out what services your health insurance pays for. You must also find out the requirements of being covered. For instance, you might need to get the insurance company's OK in advance before you can receive certain services.
- **Our Duty.** We will bill your insurance company for the services it pays for. And we will remind you to meet the requirements of being covered. If your insurance company tells us you owe a fee, Share Ourselves will bill you directly.

We will gladly discuss your proposed treatment and answer questions about your health insurance. But by law, your health insurance is a contract between you and the insurance company. The law requires us to collect fees from you and to send certain facts about you to your insurance company.

By signing on the next page, you agree that, except for any contract you may have with a third-party payer (like a health insurance company), you must pay for the services you get.

Health Insurance Benefits

By signing below, you agree to the following:

- Your insurance company may pay Share Ourselves directly for insurance benefits and hereby assign such benefits.
- This payment shall free the insurance company of any and all duties under a policy to the extent of such payment.
- As a Share Ourselves patient, you must pay for charges not covered by this assignment.
- Full payment is due at the time of service, unless otherwise arranged or required by law.

Release of Information to Get Payment

By signing below, you agree to the following:

- Share Ourselves may release any and all information or documentation to all parties related to getting your insurance benefits for claims sent by Share Ourselves for you.
- Your signature on this document allows your provider and all required parties to send claims to get benefits for services rendered without getting your signature on each and every claim. You will be bound on each claim as if you had signed it.
- If you wish to withdraw this release of information to get payment in the future, you must do so in writing.

By signing below, I confirm I have read, fully understand, and agree to the information above. Any questions I had about the content of this document have been answered.

Who is signing this form? Indicate with a ✓ mark:

☐ Patient ☐ Parent/Legal Guardian (if patient is a minor) ☐ Authorized Representative

_____	_____	_____
Print Name	Signature	Date

For Office Use Only

Verbal Consent

For use only if the patient and/or the patient's authorized representative requires assistance reading this form.

This document was read on _____ to the patient mentioned above (or to the patient's authorized representative) by:

_____	_____	_____
Print Name	Signature	Date

Sliding Fee Discount Application

It is the policy of Share Ourselves to provide essential services regardless of the patient's inability to pay. Discounts are offered based on family size and annual household income regardless of insurance coverage. Pleased complete the following information and return it to Share Ourselves to determine if you or members of your family are eligible for a discount. The discount will apply to all medically necessary services received at Share Ourselves, but not those services or equipment that are purchased from outside the health center or that may be considered essential services. **This form must be completed annually, or if your financial status changes, to continue to receive discounts.**

NAME			SOCIAL SECURITY OR ITIN #	
STREET	CITY	STATE	ZIP	PHONE
RESPONSIBLE PARTY (For payment)	MARITAL STATUS (Single, Married, Domestic Partner)			

Please list spouse/domestic partner and all members of your family.
(See page 2 for definition of family. Attach additional pages if needed.)

NAME	DATE OF BIRTH	NAME	DATE OF BIRTH
Self		Family Member	
Spouse/Domestic Partner		Family Member	
Family Member		Family Member	
Family Member		Family Member	
Family Member		Family Member	
Family Member		Family Member	

Annual Income
(See page 3 for definition of income.)

SOURCE	SELF	SPOUSE/DOME -STIC PARTNER	OTHER	TOTAL
Gross wages, salaries, tips, bonuses, etc.				
Income from business, self-employment, and dependents				
Unemployment compensation, workers' compensation, Social Security Payments, public assistance, veterans' payments, survivor benefits, pension or retirement income.				
Interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, assistance from outside the household, and other miscellaneous sources.				
TOTAL INCOME				

NOTE: Copies of tax returns, paystubs, or other information may be used to demonstrate income or you may sign a self-declaration form. Self-declaration is attached.

I certify that the family size and income information show above is true and correct.

Name (Print) _____

Signature _____ **Date** _____

Important Definitions

For the purposes of the Sliding Fee Discount Program (SFDP) Family is defined as: A group of two or more persons related by birth, marriage, domestic partnership, adoption, or foster care who live together for at least half of the year (or would be, if not incarcerated, in foster care, residing in a long-term care facility, attending school or deployed by the military). **Individuals who are not related and occupy the same housing unit, such as roommates, are not considered family members.**

For the purposes of the SFDP income is defined as: Modified adjusted gross income is calculated according to Medi-Cal guidelines. Countable income includes gross salary/wages, tips, capital investments, alimony, unemployment benefits, workers compensation benefits, pensions and passive or active monetary gain. Child support, Supplemental Security Income (SSI) and welfare benefits are not included. Net income of business or self-employment earnings is included.

For the purposes of the SFDP the following are examples of acceptable as proof of income:

- Two (2) most recent pay stubs
- Letter from employer on company letterhead stating hours worked per week and pay per hour
- Prior year tax return (including Schedule C, if applicable);
- Social Security Statements
- Court-ordered child support or alimony
- Unemployment check stubs
- Bank Statements
- Self-declaration of income under penalty of perjury

Patient Self-declaration of Income

PATIENT INFORMATION				
NAME				DATE OF BIRTH
STREET	CITY	STATE	ZIP	PHONE

Declaration of Employment:

I, _____, declare that I am presently: [ ] employed [ ] unemployed.

If employed, my employer's name is: _____

Employer's phone number: _____

Employer's address: _____

I declare that my household income last [ ] month or [ ] year was $_____.

I understand that sources of income include, **but are not limited to**, the following: employment by other(s), retirement funds, unemployment compensation, alimony, social security income, assets, workers' compensation, pensions, educational grants/ work-study, disability, self-employment income, union benefits, family support, as well as any other source not listed above.

Patient Statement
I certify, under penalty of perjury that the information contained above is complete and accurate to the best of my knowledge. I understand that I am signing this statement under penalty of prosecution if I knowingly give false information, which results in assistance received for which I am not eligible.

Patient Signature: _____ Date: _____

For Minors
If the person signing is under age 18, there must be consent by a parent or guardian, as follows:

I hereby certify that I am the parent or guardian of _____, named above, and do hereby give my consent without reservation to the foregoing on behalf of this person.

Parent/Guardian Signature: _____ Date: _____

Share Ourselves Staff Verification:
Share Ourselves Staff Name (Print): _____

Share Ourselves Signature: _____ Date: _____

Bill of Rights and Duties

What does it mean to be a whole-person care agency?
As a whole-person care agency, Share Ourselves believes the best way to care for people is to give them more than just medical care. We know that services like dental care, behavioral health care, and more, are important to overall health. Our goal is to give many of these important services in a planned and linked way.

You Have the Right To

- Be treated with dignity and respect.
  - Not to be treated differently because of your sex, gender, gender identity/gender expression, sexual orientation, age, race, color, religion, ethnicity, or ability.
  - Open and honest communication in a language you understand.
  - A relationship with your health care provider that is caring and based on kindness.
- Care and wellbeing of the whole person.
  - Get care for your body, mind, and spirit.
  - Person-centered care that suits the mission and values of Share Ourselves.
  - Health care that focuses on prevention and wellness.
  - Involve spirituality, religion, and/or personal beliefs in your care.
- Be an active partner in your care.
  - Play an active role in your care to the extent allowed by law. For instance, you have the right to say no to any tests, treatments, or care offered to you.
  - Let your family work closely with your health care team to ensure you have well planned care.
  - Challenge any choice you don't agree with by making a complaint or appeal.
  - Get a second opinion if you wish.
  - Tell us if the information in your health record is wrong or incomplete.
- Get information.
  - Get timely facts about your health and health status so you can make informed choices about your care. Except in an emergency, we will tell you about procedures, treatments, and the medical risks involved. We will also tell you who will do a procedure or treatment.
  - Know the names and titles of all Share Ourselves team members involved in your care.
  - Know in advance what you will pay for your services.
  - Get a copy of your health record. (Note: It will take time for us to fulfill your request.)
  - Understand any forms you are asked to sign.
- Have privacy.
  - Keep facts about you private. Except as allowed by law, Share Ourselves can't share facts about you unless you agree in writing.

You Have the Duty To

- Treat Share Ourselves team members with dignity and respect.
    - Refrain from treating them in a hostile, threatening, or vulgar manner.
    - Be free from the influence of any alcohol or illegal drugs while on Share Ourselves property.
- Be an active partner in your care.
    - Work closely with your care team to plan your care. This includes setting goals that you all agree on.
    - Understand the advice you get and ask questions when needed.
- Give us information.
    - Show us your identification and/or insurance card at each visit. This helps us make sure we have the right health record.
    - Tell us about any changes to your address, phone number, insurance coverage, or income.
    - Tell us about your health history. This includes facts about hospital stays and any medicines you take.
    - Tell us about any problems your treatments are causing.
    - Tell your care team when you need refills.
    - Tell us what care you want, and what care you don't want. We can give you examples of how to make an Advance Health Care Directive, if you'd like.
    - Tell us if your health record is wrong or incomplete.
    - Fill out required documents, such as insurance forms.
- Get needed care.
    - Go to scheduled visits on time. Call us if you are going to be late or need to cancel. We can help you reschedule your visit.
    - Follow the care plan that you and your care team made together. This includes taking your medicines as prescribed.
    - Work to make healthy choices.
    - Complete tests (like labs, x-rays, and EKGs) and see specialists in a timely way when needed

Share Ourselves Has the Duty To

- Work with you to promote your health and wellness.
- Give you custom care that fits your needs.
- Communicate with you in a language you understand.
- Be open and honest about treatment plans for your care.
- Advise you of any research or education projects that affect your care or treatment.
- Protect your privacy and personal health information.
- Treat you with respect, even when there is no cure for your health problem.
- Give you details about any services we charge you for.

Code of Conduct — Agreement

Share Ourselves aims to give the highest quality care and help to all. We strive to maintain a welcoming and safe space for excellent patient and client care. The partnership between Share Ourselves and our patients and clients requires us to work together and treat each other with respect. This is an agreement between (print name) _____ and Share Ourselves.

The following will not be allowed on Share Ourselves property:

- Violence, threats, harassment, or weapons
- Actions that create a safety risk
- Sexual misconduct (such as exposing yourself or using offensive sexual language)
- Language that is obscene, abusive, or not respectful
- Disturbing the peace
- Alcohol or illegal drugs
- Being under the influence of alcohol or illegal drugs
- Smoking or vaping within 25 feet of windows and doors
- Misusing or harming Share Ourselves property
- Wearing inappropriate clothes (such as clothes with offensive words or pictures)
- Littering
- Loitering, lingering, or idling

It is my duty to:

- Treat Share Ourselves team members with dignity and respect.
- Bide by this Code of Conduct Agreement.
- Be an active partner in my care.
- Follow all rules for setting and cancelling visits. For instance, I must call at least 24 hours in advance if I need to cancel.

By signing below, I confirm I have read, fully understand, and agree to the information above. Any questions I had about the content of this document have been answered.

Who is signing this form? Indicate with a ✓ mark:

☐ Patient ☐ Parent/Legal Guardian (if patient is a minor) ☐ Authorized Representative

_____	_____	_____
Print Name	Signature	Date

For Office Use Only

Verbal Consent

For use only if the patient and/or the patient's authorized representative requires assistance reading this form.

This document was read on _____ to the patient mentioned above (or to the patient's authorized representative) by:

_____	_____	_____
Print Name	Signature	Date

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 questions about this notice, you may contact the Share Ourselves Privacy Officer in either of the following ways:

- You can call **949-536-3987**
- You can e-mail **compliance@shareourselves.org**

You can also view additional information about Notices of Privacy Practices at the following website: https://www.hhs.gov/hipaa/for-individuals/notice-privacy-practices/index.html

Our Pledge Regarding Protected Health Information

- We understand that information about you and your health is personal. We are committed to protecting the privacy of your protected health information.
- We create a record of the care and services you receive at Share Ourselves, and we may receive similar records from others.
- We use these records to provide you with quality care and to comply with legal requirements.
- This Notice tells you about the ways we may use and disclose information about you. It also describes your rights, and the obligations we have regarding the use and disclosure of your information.
- We are required by law to do the following:
    - Make sure that information that identifies you is kept private.
    - Give you this Notice of our legal duties and privacy practices with respect to information about you.
    - Follow the terms of the Notice we currently have in effect.

Who Will Follow This Notice

This Notice describes Share Ourselves' practices and the practices of all of the following entities:

- Any health care professional authorized to enter information into your electronic health record
- Share Ourselves Pharmacy
- All employees, contractors, volunteers, staff, and other Share Ourselves personnel

There may also be other state and federal laws that Share Ourselves and other health care providers will follow that provide additional protections related to:

- Communicable disease
- Mental health
- Substance or alcohol abuse
- Other health conditions

How Share Ourselves May Use or Disclose Your Protected Health Information

Following are the different ways we may lawfully use or disclose your protected health information. The examples provided in each section do not represent all the ways your protected health information may be used. They are only intended to generally describe situations when uses or disclosures may happen.

1. **For Treatment**
    a. We may use your protected health information to provide you with comprehensive medical, dental, pharmacy, and social services. For example:
        i. We may disclose protected health information about you to Share Ourselves doctors, nurses, technicians, case workers, and other Share Ourselves employees who are involved in providing the care you need.
        ii. We may also share your protected health information with a provider or entity outside of Share Ourselves in order to provide or coordinate services for you such as ordering outside lab work or an x-ray.
2. **For Payment**
    a. We may use and disclose your protected health information to obtain payment for the services we provide. For example:
        i. We give your health insurance plan the information it requires before it will pay us.
    b. We may also contact a health insurance plan or a third-party payor about a treatment or service you are going to receive in the future. We would do this so we can obtain prior approval or to determine what your insurance plan may cover.
3. **For Health Care Operations**
    a. We may use and disclose your protected health information to operate this clinic. These types of uses and disclosures are necessary to run Share Ourselves and ensure that all our patients and clients receive quality care. For example:
        i. We may use medical information to review our treatment and services and to evaluate the staff caring for you.
        ii. We may also combine information about many clinic patients together to make operational decisions, for example, to determine what additional services the clinic should offer, or if a certain treatment is effective.
        iii. We may also disclose information to our staff for learning and review purposes.
        iv. We may also compare the information we have with other clinics or organizations to compare how we are doing and to make improvements in the services and care we offer.
        v. We may remove information that identifies you from these sets of medical information so that others may use it without learning who the specific patient is.
    b. We may also share your protected health information with a third-party "business associate" who is assisting us with clinic operations. We have a written contract with each of these business associates which requires them to protect the confidentiality of your protected health information. For example:
        i. We might share protected health information with a billing service performing administrative services.
        ii. We might share protected health information with an information technology firm assisting us with our electronic medical record maintenance.
4. **For Health-related Benefits and Alternative Services**
    a. We may use and disclose protected health information to tell you about health-related services, benefits, or programs that might benefit you.
    b. We may also disclose protected health information to tell you about or recommend possible treatment options or alternatives.
5. **To Individuals Involved in Your Care**
    a. We may release your protected health information to a friend or family member who is involved in your care or who helps pay for your care.
        i. Note: If you have given someone power of attorney, or if someone is your legal guardian, that person can exercise your rights, and make choices about

your protected health information. We will make sure the person has the authority, and can act for you, before we take any action.

b. In addition, in the event of a disaster, we may disclose information about you to an entity assisting in a disaster relief effort.
    i. Note: California law requires that only basic information such as your name, city of residence, age, sex, and general condition be provided in response to a disaster welfare inquiry.

6. As Required by Law

a. We will disclose your protected health information when required to do so by federal, state, or local law. For example:
    i. In some circumstances the law may require your physician to report instances of abuse, violence, or neglect.

7. To Avert a Serious Threat to Health or Safety

a. We may use or disclose your protected health information 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, or lessen the threat.

8. For Research Purposes

a. Share Ourselves may participate in research projects conducted by various entities. All research projects are reviewed and approved through a special review process to protect patient safety, welfare, and confidentiality.
b. Your protected health information may be important to research efforts and the development of new knowledge. We may use and disclose protected health information for this purpose.
c. Research studies may be performed using information about your treatment without requiring informed consent. For example:
    i. A research study may involve comparing the health of patients who receive one medication to those patients on another medication.

9. Public Health Activities

a. We may disclose information about you to various public health entities for public health purposes. These purposes generally include the following:
    i. Preventing or controlling diseases (such as cancer and tuberculosis), injury, or disability.
    ii. Reporting vital events such as births and deaths.
    iii. Public health surveillance, investigations, interventions, or at the direction of a public health authority.
    iv. Providing it to an official of a foreign government agency acting in collaboration with a public health authority.
    v. Reporting child abuse or neglect.
    vi. Reporting adverse events or reactions related to foods, drugs, or products.
    vii. Notifying people of recalls, repairs, or replacements of products they may be using.
    viii. Notifying a person who may have been exposed to a disease or who may be at risk of contracting or spreading a disease or condition.
    ix. Notifying the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence, and make this disclosure as required or authorized by law.

10. Health Oversight Activities

a. We may disclose protected health information to governmental, licensing, auditing, and accrediting agencies for activities authorized by federal and California law.

11. Lawsuits and Other Legal Actions

a. We may disclose information about you in response to a court or administrative order, or in response to a subpoena, discovery request, warrant, summons, or other lawful proceeding.

12. Law Enforcement

a. We may disclose your protected health information to law enforcement officials upon their request, for any of the following reasons:
    i. In response to a court order, subpoena, warrant, investigative demand, or other similar process.
    ii. To help 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 victim's agreement.
    iii. About a death we believe may be the result of criminal conduct; about criminal conduct occurring on our premises.
    iv. 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.

13. Coroners, Medical Examiners, and Funeral Directors

a. We may, and are often required by law, to disclose your protected health information to coroners, medical examiners, and/or funeral directors. This is done to assist these professionals with their investigation of death or to help them carry out their professional duties.

14. Organ and Tissue Donation

a. We may disclose your protected health information to organizations involved in obtaining, storing, or transplanting organs and tissues.
b. You may request, in writing, a restriction on how much information we share when responding to requests about the appropriateness of obtaining, storing, or transplanting organs and tissue. For example:
    i. Since HIV is usually a reason not to do these activities, you may ask us in writing to simply say it is not medically appropriate, without providing more information about the reasons why it is not appropriate.

15. Military, National Security, and Intelligence Activities

a. We may disclose your protected health information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.
b. We may also release protected health information about you to federal officials so they may provide protection to the President, other authorized persons, or foreign heads of states.

16. Inmates

a. If you are an inmate of a correctional institution, or under the custody of law enforcement officials, we may release your protected health information to the correctional institution or to a law enforcement official.
b. This release would be necessary for any of the following reasons:
    i. For the institution to provide you with health care.
    ii. To protect your health and safety or the safety of others.
    iii. For the safety and security of the correctional institution.

17. Worker's Compensation

a. We may disclose your protected health information as necessary to comply with Worker's Compensation laws.
b. These programs provide benefits for work-related injuries or illnesses. For example:
    i. If your care is covered by Worker's Compensation, we will make periodic reports to your employer about your condition.
    ii. We are also required to report cases of occupational injury or occupational illness to the employer or Worker's Compensation insurer.

18. Outreach and Fundraising Activities

a. We will not use or disclose your protected health information in any of our outreach or fundraising activities.
b. However, we may use combined demographic data about many people for such activities. For example:
    i. We might create a brochure to hand out at events that lists the number of Share Ourselves patients and provides basic demographic information about our patients in general.
    ii. We may also send out fundraising information to individuals who have made donations in the past or who may make donations in the future, and to past patients.
c. If you want to exclude your personal information from being used in this way, notify the Privacy Officer at the telephone number or e-mail address listed at the top of this Notice.

19. Psychotherapy Notes

a. We will not use or disclose your psychotherapy notes without your express written consent, except in limited circumstances related to payment, treatment, and other health care operations, as allowable by law.

20. Marketing and Sales

a. We will never use your information for marketing purposes without first obtaining your express written consent.

Your Rights Regarding Your Protected Health Information

1. Your Right to Inspect and Copy

a. With certain exceptions, you have the right to inspect and copy your protected health information. To access your protected health information, you must submit a request, in writing, to:

    Health Information Management
    Share Ourselves
    20151 SW Birch St.
    Suite 100 Newport Beach, CA 92660

b. If you request a copy of this information we will provide it to you within 15 days, and we may charge you a reasonable fee. If there are any circumstances which prevent us from fulfilling your request within 15 days, we will notify you of the delay.
c. We may deny your request under limited circumstances. If we deny your request to access your records, you have the right to appeal our decision. If we deny your request to access your psychotherapy notes, you have the right to have them transferred to another health professional.
d. If your written request clearly, conspicuously, and specifically asks us to send an electronic copy of your medical record to you or another person or entity, and we do not deny the request, we will send a copy of the electronic record as you requested and will charge you no more than what it costs us to respond to your request.

2. Your Right to Amend or Supplement

a. If you feel the information that we have about you is incorrect or incomplete, you may ask us to amend the information or add an addendum.
b. You have the right to seek an amendment or addendum for as long as the information is kept by Share Ourselves.
c. To request an amendment or addendum, a request must be made, in writing, and submitted to:

Health Information Management
Share Ourselves
20151 SW Birch St.
Suite 100
Newport Beach, CA 92660

d. In addition, you must provide a reason that supports your request.
e. An addendum may not be more than 250 words per alleged incomplete or incorrect item in your record.
f. We may deny your request for an amendment or an addendum regarding your protected health information or record for any of the following reasons:
    i. The request is not in writing.
    ii. The health information was not created by Share Ourselves, is not part of the designated record set.
    iii. The health information is already accurate and complete.
    iv. The health information is not information you are permitted to review (as outlined in §164.524 of the Health Insurance Portability and Accountability Act).
g. If we deny your request we will explain why, in writing, within sixty (60) days.

3. Your Right to An Accounting of Disclosures

a. You have a right to receive an "accounting of disclosures." The accounting is a list of the disclosures of your protected health information we have made in the last six (6) years that were for purposes other than treatment, payment, or health care operations, and certain other purposes.
b. To request an accounting of disclosures, you must submit your request, in writing to:

Health Information Management
Share Ourselves
20151 SW Birch St.
Ste. 100
Newport Beach, CA 92660

c. Your request should also indicate in what form you want the list (for example, on paper or electronically).
d. The first request within a 12-month period will be free. For additional lists we may charge you for the costs of providing the list. We will notify you of the cost and you may choose to withdraw or modify your request.

4. Your Right to Request Restrictions

a. You have the right to request a restriction or limitation on the protected health information we use or disclose about you for treatment, payment, or health care operations.
b. You also have the right to request a limit on the protected health 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:
    i. You could ask that we not use or disclose information about a specific medication you are taking.
c. To request restrictions, you must make your request in writing to:

Health Information Management
Share Ourselves
20151 SW Birch St.
Ste. 100
Newport Beach, CA 92660

d. In your request you must tell us:
    i. What information you want to limit;
    ii. whether you want to limit our use, disclosure, or both; and
    iii. to whom you want these limits to apply (for example, disclosures to your spouse).
e. In general, we are not required to agree with your request.
f. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment, or we are compelled to disclose the information under the law.
g. However, if you tell us not to disclose health information to your commercial health insurance plan, and you pay for the services out-of-pocket and in full at the time of service, we are required by law to comply with your request.

5. Your Right to Request Confidential Communications

a. You have the right to request that you receive your protected health information in a specific way or at a specific location. For example:
    i. You may ask that we send information to your work address.
b. We will comply with all reasonable requests submitted in writing to:

    Health Information Management
    Share Ourselves
    20151 SW Birch St.
    Ste. 100
    Newport Beach, CA 92660

c. The request must specify how or where you wish to receive these communications. We must comply with your request if you inform us that not doing so will put you in danger.

6. Your Right to a Paper Copy of this Notice

a. You can receive a paper copy of this Notice even if you have previously received this Notice electronically.
b. If you would like to have a more detailed explanation of these rights, or if you would like to exercise one or more of these rights, contact our Privacy Officer at the telephone number or e-mail address listed at the top of this Notice.

Breach Notification

If, despite Share Ourselves' efforts to keep your protected health information confidential, a breach of unsecured protected health information occurs, we will notify you as required by law. In some instances, our business associate may provide the notification. The law also requires us to report any breach of protected health information to both state and federal authorities.

The OCHIN Collaborative

Share Ourselves is part of an organized health care arrangement which includes other participants in OCHIN. A current list of OCHIN participants is available at www.ochin.org As a business associate of Share Ourselves, OCHIN supplies information technology and related services to Share Ourselves and other OCHIN participants. OCHIN also engages in quality assessment and improvement activities on behalf of its participants. For example, OCHIN coordinates clinical review activities on behalf of participating organizations to establish best practice standards and access clinical benefits that may be derived from the use of electronic health record systems; OCHIN also helps participants work collaboratively to improve the management of internal and external patient referrals.

Use of your protected information by OCHIN or a Health Information Exchange (HIE). Your protected health information may be shared by Share Ourselves with other OCHIN participants or a health information exchange (HIE) only when necessary for medical treatment or for the health care operation purposes of the organized health care arrangement. OCHIN also engages in quality assessment and improvement activities on behalf of its participants. For example, health care operation can include, among other things, geocoding your residence location to improve the clinical benefits you receive. The protected health information may include past, present, and future medical information as well as information outlined in the Privacy Rules.

The information, to the extent disclosed, will be disclosed consistent with the Privacy rules or any other applicable laws as amended from time to time. You have the right to change your mind and withdraw this consent, however the information may have already been provided as allowed by you. This consent will remain in effect until revoked by you in writing. If requested, you will be provided a list of entities to which your information has been disclosed. We participate in one or more health information exchanges (HIEs) and may electronically share your medical information for treatment, payment, and healthcare operations purposes with other participants in the HIEs.

HIEs allow health care providers to efficiently access and use medical information necessary to your treatment and other lawful purposes. The inclusion of your medical information is voluntary and, subject to your right to opt-out of this exchange of information, we may provide your medical information in accordance with applicable law to the HIEs in which we participate. For more information on any HIE in which we participate, and how you can exercise your right to opt-out, please contact the Privacy Officer at the telephone number or e-mail address at the top of this Notice.

Changes to this Notice of Privacy Practices

We reserve the right to change Share Ourselves' privacy practices and this Notice at any time. Until a change is made, we are required by law to comply with this Notice. After a change is made, the revised Notice of Privacy Practices will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception areas and will offer you a copy at your next appointment after changes have been made. We will also post the current notice on our website.

Complaints

Complaints regarding our Notice of Privacy Practices, or how Share Ourselves handles your protected health information, should be directed to our Privacy Officer at the telephone number or e-mail address listed at the top of this Notice. You will not be penalized or retaliated against for filing a complaint. If you are not satisfied with how Share Ourselves handles a complaint, you may take any of the following steps:

- You may submit a formal written complaint to the Office of Civil Rights at:

  Centralized Case Management Operations
  U.S. Department of Health and Human Services 200 Independence Avenue, S.W.
  Room 509F HHH Bldg.
  Washington, D.C. 20201

- Or you may email your complaint to: OCRComplaint@hhs.gov
- To file a complaint online, visit https://ocrportal.hhs.gov/ocr/cp/wizard_cp.jsf
- For more information on filing a complaint with the Office of Civil Rights, visit https://www.hhs.gov/hipaa/filing-a-complaint/complaint-process/index.html

Acknowledgements

Share Ourselves must tell you about certain important facts and give you certain documents. This document lets you confirm that we've done so.

Please read each section below carefully. **Write your initials on the line beside your response.**

Notice of Privacy Practices

_____ I got a copy of the Notice of Privacy Practices.

_____ Share Ourselves offered me a copy of the Notice of Privacy Practices, but I did not take it.

Patient Bill of Rights and Duties

_____ I got a copy of the Patient Bill of Rights and Duties.

_____ Share Ourselves offered me a copy of the Patient Bill of Rights and Duties, but I did not take it.

Personal Items

Share Ourselves can't be held liable if any of my personal items are damaged, lost, or stolen while I'm on Share Ourselves property

_____ I understand.

Federal Tort Claims Act

The Health Resources and Services Administration (HRSA) considers Share Ourselves and its officers, governing board members, full- and part-time employees, providers, and contractors to be Federal Public Health Service employees. As such, the covered individuals are granted liability protection under the Federal Tort Claims Act (FTCA) with respect to certain health or health-related claims, including malpractice claims. With this coverage, any limits that may be required by other entities are met.

_____ I understand.

Advance Health Care Directive

Did Share Ourselves give you facts about advance health care directives?

_____ Yes, Share Ourselves gave me facts about advance health care directives.

_____ Share Ourselves offered me facts about advance health care directives, but I didn't take them.

Did you give Share Ourselves your advance directive, living will, or durable power of attorney so we can add it to your health record?

_____ Yes, I gave a copy to Share Ourselves. _____ No, I didn't give a copy to Share Ourselves.

By signing below, I confirm I have read, fully understand, and agree to the information above. Any questions I had about the content of this document have been answered.

Who is signing this form? Indicate with a ✓ mark:

☐ Patient ☐ Parent/Legal Guardian (if patient is a minor) ☐ Authorized Representative

_____	_____	_____
Print Name	Signature	Date

For Office Use Only

Verbal Consent

For use only if the patient and/or the patient's authorized representative requires assistance reading this form.

This document was read on _____ to the patient mentioned above (or to the patient's authorized representative) by:

_____	_____	_____
Print Name	Signature	Date