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PATIENT REGISTRATION

Note: This form may be completed manually or on your computer. To complete this form on your computer: *1. Type your answer in each field. 2. Save your work often on your computer or device. 3. Print the completed form and bring it with you to your first appointment.*

How did you hear about us?
- ☐ Newspaper
- ☐ Social media/Web search
- ☐ Insurance directory
- ☐ Family/Friend

PATIENT INFORMATION

NAME (LAST, FIRST , M.I.)	SSN	BIRTHDATE

LANGUAGE	PRIMARY CARE PROVIDER	CURRENT GENDER MALE FEMALE UNDIFFERENTIATED

BILLING ADDRESS (STREET, APT OR UNIT #)	CITY	STATE	ZIP
PHYSICAL ADDRESS (IF DIFFERENT FROM BILLING ADDRESS	CITY	STATE	ZIP

CELL PHONE XXX-XXX-XXXX	HOME PHONE XXX-XXX-XXXX	DAY PHONE XXX-XXX-XXXX	EMAIL ADDRESS (EXAMPLE@TEST.COM)

PREFERRED CONTACT METHOD (REQUIRED) CELL HOME DAY EMAIL	MARITAL STATUS	MOTHER'S MAIDEN NAME	RACE	ETHNICITY

EMERGENCY CONTACT NAME	PHONE NUMBER XXX-XXX-XXXX

PRIMARY EMPLOYER	SECONDARY EMPLOYER (If applicable)
ADDRESS (STREET, SUITE#)	ADDRESS (STREET, SUITE#)
CITY, STATE, ZIP	CITY, STATE, ZIP

WORK PHONE XXX-XXX-XXXX	OCCUPATION	WORK PHONE XXX-XXX-XXXX	OCCUPATION

POLICYHOLDER/GUARANTOR (If different than patient)

NAME (LAST, FIRST, M.I.)	SSN	BIRTHDATE

LANGUAGE	PRIMARY CARE PROVIDER	CURRENT GENDER MALE FEMALE UNDIFFERENTIATED

BILLING ADDRESS (STREET, APT OR UNIT #)	CITY	STATE	ZIP
PHYSICAL ADDRESS (IF DIFFERENT FROM BILLING ADDRESS)	CITY	STATE	ZIP

CELL PHONE XXX-XXX-XXXX	HOME PHONE XXX-XXX-XXXX	DAY PHONE XXX-XXX-XXXX	EMAIL ADDRESS (EXAMPLE@TEST.COM)

PREFERRED CONTACT METHOD (REQUIRED) CELL HOME DAY EMAIL	MARITAL STATUS	MOTHER'S MAIDEN NAME	RACE	ETHNICITY

RELATIONSHIP TO PATIENT

PRIMARY INSURANCE

NAME OF INSURANCE COMPANY	POLICY #

NAME OF POLICY HOLDER	DOB	RELATIONSHIP TO PATIENT	GROUP #	COPAY AMT $	DEDUCTIBLE AMT $

ADDRESS OF INSURANCE COMPANY (STREET, SUITE #, CITY, ST, ZIP)	PHONE XXX-XXX-XXXX	EFFECTIVE DATE	EXPIRATION DATE

SECONDARY INSURANCE

NAME OF INSURANCE COMPANY	POLICY #

NAME OF POLICY HOLDER	DOB	RELATIONSHIP TO PATIENT	GROUP #	COPAY AMT $	DEDUCTIBLE AMT $

ADDRESS OF INSURANCE COMPANY (STREET, SUITE #, CITY, ST, ZIP)	PHONE XXX-XXX-XXXX	EFFECTIVE DATE	EXPIRATION DATE

FINANCIAL POLICY: Payment in full or co-payment is expected at the time of service. Services provided that are not a covered benefit of your health plan will be your responsibility.
CONSENT TO TREATMENT/RELEASE OF INFORMATION: I grant Graybill Medical Group, Inc. to administer medical treatment and perform medical procedures as deemed necessary. I authorize the release of medical information to my insurer, or the insurer's agents to process my payments for service. To the best of my knowledge, all of the information above is true and correct.
ASSIGNMENT OF BENEFITS: I thereby assign all benefits payable by my insurance company to Graybill Medical Group.

PATIENT/GUARDIAN SIGNATURE ______________________ DATE ____________ RELATIONSHIP TO PATIENT ______________________

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PATIENT FINANCIAL AGREEMENT

- **Co-Payments:** Your insurance company requires us to collect co-payments at the time of service. Waiver of co-payments may constitute fraud under state and federal law. Please help us in upholding the law by paying your co-payment at each visit.
- **Deductible Payments:** If your insurance requires you to meet a deductible before services are covered, payment must be made at the time of service. A $100.00 payment will be due at the time of service. Please note the $100.00 payment does not constitute payment in full and any additional balance must be paid upon receiving notification from our practice.
- **Claims Submission:** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Payment from your insurance company is expected within 45 days. After 45 days, we will look to you for payment in full. You will be responsible for all non-covered services according to Medicare guidelines. We must have a copy of your most recent cards and any secondary insurance or supplement you may have. Accounts that are 90 days past due are subject to being sent to a collection agency or small claims court for the unpaid bills. If we receive notification that you are not eligible for coverage or we are not contracted with your insurance, you will be responsible for all charges incurred. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request.
- **Preventive Care Services:** Routine exams are not always covered by your insurance. Please be aware that if an additional problem is addressed at the time of your visit, a co-pay, deductible or office visit fee may be charged. If services are denied for payment by your insurance or you have failed to provide us with your correct insurance information, you will be responsible to pay for these services.
- **Cash Pay Patients:** The amount you pay for today's scheduled office visit may not be your final payment. Other costs that may be accrued for today's appointment are including, but not limited to, laboratory tests, x-ray tests, any injections, special procedures or additional office visit charges.
- **Laboratory Bills:** Any laboratory procedures that are ordered during today's visit will be billed to you directly by the laboratory. Please contact your laboratory directly for any questions regarding your lab bill.
- **Missed Appointments:** Please note a $25.00 cancellation fee will apply for missed appointments or failure to cancel within 24 hours prior to your scheduled appointment time. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.
- If at any time you should experience financial hardship and need to make special payment plan arrangements, please contact our billing office.

Assignment of Benefits: Authorization is hereby granted to release information as may be necessary to process and complete my insurance claim, and payment of medical benefit is to be paid directly to Graybill Medical Group for all services rendered. *Initials:* ________

I have read and understand the above statements. I agree to comply with the financial policies of the office and I am financially responsible for my account.

Patient or Guardian Signature: ___________________________________ *Date:* ___________________

Patient Name (please print) ____________________________________ *Date of Birth:* ______________

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

GRAYBILL MEDICAL GROUP

Privacy Officer (760) 291- 6696

I hereby acknowledge that I have been offered a copy of Graybill Medical Group's Notice of Privacy Practices. I have been advised that a copy of the current notice will be posted in the reception area, and that any amended Notice of Privacy Practices will be available at each appointment.

____ ____________________

PATIENT NAME (please print) PATIENT DATE OF BIRTH

____ ____________________

PATIENT/GUARDIAN SIGNATURE DATE

___________________ ____

PATIENT PHONE XXX-XXX-XXXX NAME OF PHYSICIAN

If not signed by the patient, please indicate relationship:

Parent or guardian of minor patient

Guardian or conservator of an incompetent patient

Beneficiary or personal representative of deceased patient

☐ I would like to receive a copy of any amended Notice of Privacy Practices via e-mail.

My email address is: ____

PERMISSION TO DISCUSS PROTECTED HEALTH INFORMATION WITH OTHERS

I hereby grant permission to Graybill Medical Group to speak to the following individuals about my health and disclose my health information including billing and insurance. I understand this authorization does not include information regarding HIV, psychiatric, drug and/or alcohol records, which must be authorized on a separate release.

	NAME	DOB
Spouse	______________________________	____________________
Children	______________________________	____________________
	______________________________	____________________
	______________________________	____________________
Guardian	______________________________	____________________
Caregiver	______________________________	____________________
Sister	______________________________	____________________
Brother	______________________________	____________________
Friend	______________________________	____________________
Emergency Contact	______________________________	____________________
Other	______________________________	____________________

You may discuss my (please check all that apply)

Visit Notes   Laboratory Results   X-rays   Reports   All Services and Treatment Rendered

I understand that I may revoke this authorization at any time in writing.

Patient Name (please print)__________________________ Patient Date of Birth______________

Patient/Guardian Signature__________________________________ Date___________________

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TB QUESTIONNAIRE

Patient Name ______________________________ Date of Birth ___________________

Today's Date ________________________

1. Have you ever had TB (Tuberculosis)? Yes No
2. Have you been living with anyone in the past 2 years who has been diagnosed with TB? Yes No
3. Have you had a persistent cough and night sweats for more than 2 weeks? Yes No
4. Have you had a persistent cough and fever for more than 2 weeks? Yes No
5. Have you had a persistent cough and loss of appetite for more than 2 weeks? Yes No
6. Have you been coughing up or spitting up bloody sputum (saliva)? Yes No

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ADULT HISTORY AND REVIEW OF SYMPTOMS QUESTIONNAIRE

PATIENT NAME				TODAY'S DATE
PATIENT DATE OF BIRTH	☐ MALE ☐ FEMALE	NAME OF SPOUSE/SIGNIFICANT OTHER		

SOCIAL HISTORY

BIRTHPLACE		PATIENT'S OCCUPATION		
NATIONALITY		EDUCATION		
RELIGION		MARITAL STATUS		# YEARS?
RECREATIONAL DRUG USE? YES NO	TYPE	CHILDREN ______ ______		
TOBACCO USE? YES NO	TYPE			
# PACKS PER DAY	# YEARS	LAST USED	PETS	
ALCOHOL USE? YES NO	# DRINKS ______ per Day Week Month	EXERCISE YES NO	TYPE	HOW OFTEN?
IF HEAVY USE, HOW MANY YEARS?	LAST USED	RECENT OR FREQUENT TRAVEL DESTINATIONS ______ ______		
CAFFEINE USE? YES NO	TYPE	# CUPS / DAY		

MEDICAL CONDITIONS

Have YOU ever had (check appropriate boxes):

Cancer / Type ______________
Heart attack
Coronary artery disease
Rheumatic fever
Heart failure
High blood pressure
High cholesterol
Stroke
Diabetes
Gallstones
Liver disease
Hepatitis/Jaundice
Ulcer disease
Heartburn / Reflux
Asthma
Seizures

Emphysema
Pneumonia
Tuberculosis
Positive TB skin test
Osteoporosis
Arthritis
Gout
Frequent bladder infection
Kidney stones
Kidney disease
Polio
Chicken pox
Infectious mono
Anemia
Frequent sinus infections

Glaucoma
Thyroid issues
Hives
Depression
Head injury
Broken bones
Blood transfusions
Sexually transmitted diseases: Herpes, HIV, etc.
Gonorrhea, Chlamydia
Syphilis
Intravenous drug abuse
Needle injury
Mumps
Migraines

Prostate enlargement
Cystic fibrosis
Malaria
Other: ______________________
____

IMMUNIZATIONS

Measles, Mumps and Rubella Vaccine
Chicken Pox Vaccine
Hepatitis B Vaccine
Influenza Vaccine
Pneumococcal Vaccine
Tetanus Booster

PAST SURGICAL HISTORY (If applicable, please check the box and enter the year)

	YEAR		YEAR		YEAR
Eyes (laser or vision corrected)	______	Gall bladder	______	Spinal surgery/back	______
Eyes (cataract/glaucoma)	______	Intestine/colon	______	Orthopedic (hips/knees)	______
Ears	______	Hemorrhoids	______	Shoulders/feet/hands	______
Sinus/nasal septum	______	Hernia	______	C-Section	______
Tonsils/adenoid	______	Breast	______	Vasectomy	______
Thyroid	______	Uterus/hysterectomy	______	Tubal ligation	______
Heart	______	Ovaries	______	OTHER ______________	______
Stomach	______	Spinal surgery/neck	______		______
Varicose veins	______	Prostate	______________ ______		______
			______________		

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ADULT HISTORY AND REVIEW OF SYMPTOMS QUESTIONNAIRE (continued)

PATIENT NAME	PATIENT DATE OF BIRTH

CURRENT MEDICATIONS

NAME	DOSE	TIMES/DAY
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		

Allergies or adverse reactions to medications? ____

FAMILY MEDICAL HISTORY

Has anyone in your FAMILY ever had any of the following (check appropriate boxes and list relationship):

	Relationship		Relationship		Relationship
Cancer/Type		Dialysis	____________	Crohn's/colitis	____________
____________________	____________	Chronic lung disease	____________	Alzheimer's	____________
Diabetes	____________	Tuberculosis	____________	Alcoholism	____________
Cardiac/dysrhythmia	____________	Rheumatoid arthritis	____________	Bleeding tendency	____________
Congestive heart failure	____________	Thyroid issues	____________	Anemia	____________
Coronary artery disease	____________	Osteoporosis	____________	Gout	____________
Valvular heart disease	____________	Cystic fibrosis	____________	Depression	____________
High blood pressure	____________	Asthma	____________	Mental illness	____________
High cholesterol	____________	Peptic ulcer	____________	Seizures	____________
Stroke	____________	Gallstones	____________	Migraine headaches	____________
Kidney stones	____________				
Kidney disease	____________				

OTHER ____ Relationship ______________

GYNECOLOGICAL / OBSTETRICAL HISTORY

Name of OB/GYN (please print): ____

Age when you started menstruating: ______________ Number of pregnancies: ______________

Date of last Pap smear: ______________ Number of births: ______________

History of abnormal Pap smears? Yes No Vaginal C-Section

Date of last mammogram: ______________ Method of contraception: ______________

History of abnormal mammograms? Yes No

Menstrual cycles? Regular Irregular

Painful periods? Yes No

Age at menopause: ______________

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ADULT HISTORY AND REVIEW OF SYMPTOMS QUESTIONNAIRE (continued)

PATIENT NAME	PATIENT DATE OF BIRTH

Have you been feeling any of these symptoms recently?

GENERAL

Fever   Fatigue   Night sweats

Other ______________________________________

HEAD, EYES, EARS, NOSE & THROAT

Vision changes   Headaches

RESPIRATORY

Shortness of breath   Cough

CARDIOVASCULAR

Chest pain   Palpitations

VASCULAR

Leg cramps with exercise

GASTROINTESTINAL

Vomiting   Diarrhea   Constipation

GENITOURINARY

Burning with urine   Blood in the urine

METABOLIC/ENDOCRINE

Cold intolerance   Heat intolerance

NEURO/PSYCHIATRIC

Dizziness   Anxiety   Depression

DERMATALOGIC

Rash   Itching

MUSCULOSKELETAL

Back pain   Joint pain

HEMATOLOGIC

Easy bruising   Easy bleeding

IMMUNOLOGICAL/ALLERGY

Food allergies   Environmental allergies

Any other symptoms not mentioned above?

____

____

____

____

____

____

____

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ADULT HISTORY AND REVIEW OF SYMPTOMS QUESTIONNAIRE (continued)

PATIENT NAME	PATIENT DATE OF BIRTH

PHARMACY

Your prescriptions will be sent electronically to the pharmacy of your choice. To which pharmacy may we send your prescriptions? (Please check below.)

CVS Wal-Mart Rite Aid Walgreens Target Sav-On Costco

Other: ____

Location (cross street and city): ____

Best number to reach you if we have additional questions: ____

HEALTH MAINTENANCE

When was your last physical? _______________

When was your last cholesterol blood work? _______________

If over age 50, when was your last colon cancer screening? _______________ Sigmoidoscopy Colonoscopy

If over age 65, when was your last DEXA (bone density) screening? _______________

If female, when was your last Pap smear? _______________

If female over age 40, when was your last mammogram? _______________

VACCINATIONS

Please list, to the best of your knowledge, the most recent date you received the following vaccine(s):

1. Tetanus _______________
2. Flu vaccine (given annually from the Fall to Spring) _______________
3. Pneumonia vaccine (if over 65 or certain health conditions) _______________
4. Shingles vaccine (if over age 60) _______________

Are you interested in receiving any of the above? Yes No

ADVANCE DIRECTIVE

Do you have an Advance Directive? Yes No

Would you like to discuss Advance Directives? Yes No

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AUTHORIZATION TO RELEASE MEDICAL RECORDS

Phone: (760) 291-6708
Fax: (760) 291-6889

Patient Name	Patient Date of Birth

Treatment, payment, enrollment or eligibility for benefits will not be conditioned on my providing or refusing to provide this authorization.

I hereby authorize the disclosing physician or health care provider noted below to release medical information to the receiving physician or health care provider indicated:

FROM:		**TO:**	Graybill Medical Group
	(Disclosing physician or provider)		***(Receiving physician or provider)***
			225 E. 2nd Avenue
	(Street Address)		***(Street Address)***
			Escondido, CA 92025
	(City, State, Zip Code)		***(City, State, Zip Code)***

Release records and information regarding: ______________________________

(Patient's Name)

______________________ ______________________ ______________________

(Date of Birth) ***(Social Security #)*** ***(Telephone Number)***

____

(Address, City, State, Zip Code)

DURATION: This Authorization shall become effective immediately and shall remain in effect through ________________________ (enter date) or for one year from the date of signature if no date entered.

REVOCATION: This Authorization is also subject to written revocation by the undersigned at any time between now and the disclosure of information by the disclosing party. Written revocation will be effective upon receipt, but will not be effective to the extent that the Requestor or others have acted in reliance upon this Authorization.

REDISCLOSURE: I understand that the requestor may not lawfully further use or disclose the health information unless another Authorization is obtained from me or unless the disclosure is specifically required or permitted by law.

AUTHORIZATION TO RELEASE MEDICAL RECORDS (continued)

SPECIFY RECORDS: ☐ **Medical Information** ☐ **X-Ray/Other Imaging**

☐ **Psychiatric** ______________________________ ______________

Signature *Date*

☐ **Drug/Alcohol** ______________________________ ______________

Signature *Date*

☐ **HIV Test Results** ______________________________ ______________

Signature *Date*

☐ **Genetic Testing** ______________________________ ______________

Signature *Date*

☐ **Other (specify)** ____

______________________________ ______________

Signature *Date*

REQUESTED RECORDS TO BE PROVIDED VIA: **Paper** **CD/Other Portable Storage** **Electronically via NextMD**

I request that the health information released pursuant to this authorization be used for the following purposes only: ____

____

______________________________ ______________

Patient/Guardian Signature ***Date***

A copy of this authorization is as valid as an original. I have the right to receive a copy of this authorization and the copy is for me to keep.

______________________________ ______________

Patient/Guardian Signature ***Date***

____

Relationship to Patient (if signed by other than Patient)

CONFIDENTIAL INFORMATION MAY BE ACCESSED BY BACTES CORPORATION EMPLOYEES FOR PURPOSES OF PHOTOCOPYING INFORMATION IN RESPONSE TO PROPERLY AUTHORIZED REQUESTS FOR COPIES OF MEDICAL RECORDS.

YOUR RECORDS FOR **2 YEARS** IS ALL THAT WILL BE COPIED UNLESS OTHERWISE REQUESTED. THERE MAY BE A CHARGE FOR RECORDS OLDER THAN 2 YEARS

THE COPYING PROCESS USUALLY TAKES 15 WORKING DAYS. RECORDS WILL NOT BE FAXED.

Physician’s Order for Life Sustaining Treatment (POLST)

A Physician’s Order for Life Sustaining Treatment (POLST) outlines a plan of care reflecting a patient’s wishes concerning care at life’s end.

Unlike traditional physician’s orders, POLST is not bound to a particular site or care setting. Rather, the orders contained within a POLST must be honored across care settings and, hence, may be used by EMTs, physicians, nurses in the emergency department, hospitals, nursing facilities, and so forth.

In short, a POLST allows the physician’s order regarding end of life care to travel with a patient as the patient moves between home, the hospital, long term care facilities, etc.

This is a voluntary form which must be signed by you (or your agent) and your physician. It indicates the types of life-sustaining treatment you do or do not want if you become seriously ill. POLST asks for information about your preferences for CPR, use of antibiotics, feeding tubes, etc. It helps translate into medical orders what must be followed in all healthcare settings.

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HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

EMSA #111 B
(Effective 1/1/2016)*

Physician Orders for Life-Sustaining Treatment (POLST)

First follow these orders, then contact Physician/NP/PA. A copy of the signed POLST form is a legally valid physician order. Any section not completed implies full treatment for that section. **POLST complements an Advance Directive and is not intended to replace that document.**

Patient Last Name:	Date Form Prepared:
Patient First Name:	Patient Date of Birth:
Patient Middle Name:	Medical Record #: *(optional)*

A — Check One

CARDIOPULMONARY RESUSCITATION (CPR): ***If patient has no pulse and is not breathing. If patient is NOT in cardiopulmonary arrest, follow orders in Sections B and C.***

☐ **Attempt Resuscitation/CPR** (Selecting CPR in Section A **requires** selecting Full Treatment in Section B)

☐ **Do Not Attempt Resuscitation/DNR** (Allow Natural Death)

B — Check One

MEDICAL INTERVENTIONS: ***If patient is found with a pulse and/or is breathing.***

☐ **Full Treatment – primary goal of prolonging life by all medically effective means.**
In addition to treatment described in Selective Treatment and Comfort-Focused Treatment, use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated.

☐ ***Trial Period of Full Treatment.***

☐ **Selective Treatment – goal of treating medical conditions while avoiding burdensome measures.**
In addition to treatment described in Comfort-Focused Treatment, use medical treatment, IV antibiotics, and IV fluids as indicated. Do not intubate. May use non-invasive positive airway pressure. Generally avoid intensive care.

☐ ***Request transfer to hospital only*** *if comfort needs cannot be met in current location.*

☐ **Comfort-Focused Treatment – primary goal of maximizing comfort.**
Relieve pain and suffering with medication by any route as needed; use oxygen, suctioning, and manual treatment of airway obstruction. Do not use treatments listed in Full and Selective Treatment unless consistent with comfort goal. ***Request transfer to hospital only if comfort needs cannot be met in current location.***

Additional Orders: ____

____

C — Check One

ARTIFICIALLY ADMINISTERED NUTRITION: ***Offer food by mouth if feasible and desired.***

☐ Long-term artificial nutrition, including feeding tubes.
☐ Trial period of artificial nutrition, including feeding tubes.
☐ No artificial means of nutrition, including feeding tubes.

Additional Orders: ____

D

INFORMATION AND SIGNATURES:

Discussed with: ☐ Patient (Patient Has Capacity) ☐ Legally Recognized Decisionmaker

☐ Advance Directive dated _______, available and reviewed →
☐ Advance Directive not available
☐ No Advance Directive

Health Care Agent if named in Advance Directive:
Name: ____________________
Phone: ____________________

Signature of Physician / Nurse Practitioner / Physician Assistant (Physician/NP/PA)
My signature below indicates to the best of my knowledge that these orders are consistent with the patient's medical condition and preferences.

Print Physician/NP/PA Name:	Physician/NP/PA Phone #:	Physician/PA License #, NP Cert. #:
Physician/NP/PA Signature: *(required)*		Date:

Signature of Patient or Legally Recognized Decisionmaker
I am aware that this form is voluntary. By signing this form, the legally recognized decisionmaker acknowledges that this request regarding resuscitative measures is consistent with the known desires of, and with the best interest of, the individual who is the subject of the form.

Print Name:		Relationship: *(write self if patient)*
Signature: *(required)*	Date:	**FOR REGISTRY USE ONLY**
Mailing Address (street/city/state/zip):	Phone Number:	

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED

*Form versions with effective dates of 1/1/2009, 4/1/2011 or 10/1/2014 are also valid

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

Patient Information

Name (last, first, middle):	Date of Birth:	Gender: M F

NP/PA's Supervising Physician	**Preparer Name** (if other than signing Physician/NP/PA)	
Name:	Name/Title:	Phone #:

Additional Contact ☐ None

Name:	Relationship to Patient:	Phone #:

Directions for Health Care Provider

Completing POLST

- **Completing a POLST form is voluntary**. California law requires that a POLST form be followed by healthcare providers, and provides immunity to those who comply in good faith. In the hospital setting, a patient will be assessed by a physician, or a nurse practitioner (NP) or a physician assistant (PA) acting under the supervision of the physician, who will issue appropriate orders that are consistent with the patient's preferences.
- **POLST does not replace the Advance Directive**. When available, review the Advance Directive and POLST form to ensure consistency, and update forms appropriately to resolve any conflicts.
- POLST must be completed by a health care provider based on patient preferences and medical indications.
- A legally recognized decisionmaker may include a court-appointed conservator or guardian, agent designated in an Advance Directive, orally designated surrogate, spouse, registered domestic partner, parent of a minor, closest available relative, or person whom the patient's physician/NP/PA believes best knows what is in the patient's best interest and will make decisions in accordance with the patient's expressed wishes and values to the extent known.
- A legally recognized decisionmaker may execute the POLST form only if the patient lacks capacity or has designated that the decisionmaker's authority is effective immediately.
- To be valid a POLST form must be signed by (1) a physician, or by a nurse practitioner or a physician assistant acting under the supervision of a physician and within the scope of practice authorized by law and (2) the patient or decisionmaker. Verbal orders are acceptable with follow-up signature by physician/NP/PA in accordance with facility/community policy.
- If a translated form is used with patient or decisionmaker, attach it to the signed English POLST form.
- Use of original form is strongly encouraged. Photocopies and FAXes of signed POLST forms are legal and valid. A copy should be retained in patient's medical record, on Ultra Pink paper when possible.

Using POLST

- Any incomplete section of POLST implies full treatment for that section.

Section A:

- If found pulseless and not breathing, no defibrillator (including automated external defibrillators) or chest compressions should be used on a patient who has chosen "Do Not Attempt Resuscitation."

Section B:

- When comfort cannot be achieved in the current setting, the patient, including someone with "Comfort-Focused Treatment," should be transferred to a setting able to provide comfort (e.g., treatment of a hip fracture).
- Non-invasive positive airway pressure includes continuous positive airway pressure (CPAP), bi-level positive airway pressure (BiPAP), and bag valve mask (BVM) assisted respirations.
- IV antibiotics and hydration generally are not "Comfort-Focused Treatment."
- Treatment of dehydration prolongs life. If a patient desires IV fluids, indicate "Selective Treatment" or "Full Treatment."
- Depending on local EMS protocol, "Additional Orders" written in Section B may not be implemented by EMS personnel.

Reviewing POLST

It is recommended that POLST be reviewed periodically. Review is recommended when:

- The patient is transferred from one care setting or care level to another, or
- There is a substantial change in the patient's health status, or
- The patient's treatment preferences change.

Modifying and Voiding POLST

- A patient with capacity can, at any time, request alternative treatment or revoke a POLST by any means that indicates intent to revoke. It is recommended that revocation be documented by drawing a line through Sections A through D, writing "VOID" in large letters, and signing and dating this line.
- A legally recognized decisionmaker may request to modify the orders, in collaboration with the physician/NP/PA, based on the known desires of the patient or, if unknown, the patient's best interests.

This form is approved by the California Emergency Medical Services Authority in cooperation with the statewide POLST Task Force.
For more information or a copy of the form, visit **www.caPOLST.org**.

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED

www.graybill.org

NOTICE OF PRIVACY PRACTICES

Privacy Officer 760-291-6696

Effective Date: September 23, 2013

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our Privacy Officer listed above.

A. How Graybill Medical Group May Use or Disclose Your Health Information

The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

1. *Treatment*. We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services that we do not provide or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured, or following your death.
2. *Payment.* We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires for payment. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.
3. *Health Care Operations.* We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our "business associates," such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them and their subcontractors to protect the confidentiality and security of your medical information. Although federal law does not protect health

information which is disclosed to someone other than another healthcare provider, health plan, healthcare clearinghouse or one of their business associates, California law prohibits all recipients of healthcare information from further disclosing it except as specifically required or permitted by law.

We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their patient-safety activities, their population-based efforts to improve health or reduce health care costs, protocol development, case management or care coordination activities, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, their activities related to contracts of health insurance or health benefits, or their health care fraud and abuse detection and compliance efforts.

4. *Appointment Reminders.* We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.
5. *Sign-in Sheet.* We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.
6. *Notification and Communication with Family.* We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or, unless you had instructed us otherwise, in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.
7. *Marketing*. Provided we do not receive any payment for making these communications, we may contact you to encourage you to purchase or use products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments, therapies, health care providers or settings of care that may be of interest to you. We may similarly describe products or services provided by this practice and tell you which health plans we participate in. We may receive financial compensation to talk with you face-to-face, to provide you with small promotional gifts, or to cover our cost of reminding you to take and refill your medication or otherwise communicate about a drug or biologic that is currently prescribed for you, but only if you either: (1) have a chronic and seriously debilitating or life-threatening condition and the communication is made to educate or advise you about treatment options and otherwise maintain adherence to a prescribed course of treatment, or (2) you are a current health plan enrollee and the communication is limited to the availability of more cost-effective pharmaceuticals. If we make these communications while you have a chronic and seriously debilitating or life-threatening condition, we will provide notice of the following in at least 14-point type: (1) the fact and source of the remuneration; and (2) your right to opt-out of future remunerated communications by calling the communicator's toll-free number. We will not otherwise use or disclose your medical information for marketing purposes or accept any payment for other marketing communications without your prior written authorization. The authorization will disclose whether we receive any financial compensation for any marketing activity you authorize, and we will stop any future marketing activity to the extent you revoke that authorization.

8. *Sale of Health Information.* We will not sell your health information without your prior written authorization. The authorization will disclose that we will receive compensation for your health information if you authorize us to sell it, and we will stop any future sales of your information to the extent that you revoke that authorization.
9. *Required by Law.* As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.
10. *Public Health.* We may, and are sometimes required by law to, disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.
11. *Health Oversight Activities.* We may, and are sometimes required by law, to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by federal and California law.
12. *Judicial and Administrative Proceedings.* We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.
13. *Law Enforcement.* We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.
14. *Coroners.* We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.
15. *Organ or Tissue Donation.* We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.
16. *Public Safety.* We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.
17. *Proof of Immunization.* We will disclose proof of immunization to a school where the law requires the school to have such information prior to admitting a student if you have agreed to the disclosure on behalf of yourself or your dependent.
18. *Specialized Government Functions.* We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.

19. *Worker's Compensation.* We may disclose your health information as necessary to comply with worker's compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.
20. *Change of Ownership.* In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.
21. *Breach Notification.* In the case of a breach of unsecured protected health information, we will notify you as required by law. If you have provided us with a current email address, we may use email to communicate information related to the breach. In some circumstances our business associate may provide the notification. We may also provide notification by other methods as appropriate.
22. *Research.* We may disclose your health information to researchers conducting research with respect to which your written authorization is not required as approved by an Institutional Review Board or privacy board, in compliance with governing law.

B. When Graybill Medical Group May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, this medical practice will, consistent with its legal obligations, not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

C. Your Health Information Rights

1. *Right to Request Special Privacy Protections.* You have the right to request restrictions on certain uses and disclosures of your health information by a written request specifying what information you want to limit, and what limitations on our use or disclosure of that information you wish to have imposed. If you tell us not to disclose information to your commercial health plan concerning health care items or services for which you paid for in full out-of-pocket, we will abide by your request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any other request, and will notify you of our decision.
2. *Right to Request Confidential Communications.* You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular email account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.
3. *Right to Inspect and Copy.* You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to, whether you want to inspect it or get a copy of it, and if you want a copy, your preferred form and format. We will provide copies in your requested form and format if it is readily producible, or we will provide you with an alternative format you find acceptable, or if we can't agree and we maintain the record in an electronic format, your choice of a readable electronic or hardcopy format. We will also send a copy to any other person you designate in writing. We will charge a reasonable fee which covers our costs for labor, supplies, postage, and if requested and agreed to in advance, the cost of preparing an explanation or summary, as allowed by federal and California law. We may deny your request under limited circumstances. If we deny your request to access your child's

records or the records of an incapacitated adult you are representing because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision. If we deny your request to access your psychotherapy notes, you will have the right to have them transferred to another mental health professional.

4. *Right to Amend or Supplement.* You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. If we deny your request, you may submit a written statement of your disagreement with that decision, and we may, in turn, prepare a written rebuttal. You also have the right to request that we add to your record a statement of up to 250 words concerning anything in the record you believe to be incomplete or incorrect. All information related to any request to amend or supplement will be maintained and disclosed in conjunction with any subsequent disclosure of the disputed information.
5. *Right to an Accounting of Disclosures.* You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 18 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.
6. You have a right to notice of our legal duties and privacy practices with respect to your health information, including a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by e-mail. 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 listed at the top of this Notice of Privacy Practices.

D. Changes to this Notice of Privacy Practices

We reserve the right to amend our privacy practices and the terms of this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with this Notice. After an amendment is made, the revised Notice of Privacy Protections 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 area, and a copy will be available at each appointment. We will also post the current notice on our website.

E. Complaints

Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer listed at the top of this Notice of Privacy Practices.

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to:

Region IX - Office of Civil Rights
U.S. Department of Health & Human Services
90 7th Street, Suite 4-100
San Francisco, CA 94103
(415) 437-8310; (415) 437-8311 (TDD)
(415) 437-8329 (fax)
OCRMail@hhs.gov

The complaint form may be found at www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaint.pdf. You will not be penalized in any way for filing a complaint.