BACHC
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Patient Registration Form

Internal Use:
Interested in AHCD: _____Yes _____No
Date Received: ____/____/____
AHCD Signed: _____ Yes _____No
Staff Initials: _____

PATIENT INFORMATION *

Last Name:	First Name:	MI:	Date of Birth:	Social Security Number:

Street Address:	City:	State:	Zip Code:	County:

CONTACT INFORMATION *

Mobile Phone Number:	Home Phone Number:	Employer:	Employer Phone Number:

BACHC may contact me for clinical/appointment reminders by using the following methods (check all that apply): ☐ Email ☐ Home ☐ Cell ☐ Text (Standard data/messaging rates may apply)

Email:

Referred to clinic by (please check one): ☐Dr ☐ Insurance Plan ☐ Hospital ☐Family ☐ Friend ☐ Outreach ☐ Social Media ☐ Other:_____

Emergency Contact Name:	Relationship:	Emergency Contact Phone Number:

PATIENT DEMOGRAPHICS *

Primary Language Spoken:
☐English ☐Spanish ☐Other:_____

Would you like an interpreter?
☐Yes ☐No

Race (Check all that apply):
☐Asian ☐ Black/African American ☐ White ☐ Central American Indian
☐American Indian/Native Alaskan ☐ Pacific Islander ☐ Native Hawaiian
☐More than one race
☐Other: _____

Ethnicity:
☐Hispanic/ Latino
☐Non-Hispanic/ Latino

Gender Identity:	Sexual Orientation:	Marital Status:	Student:	Employment Status:
☐Male	☐Straight or heterosexual	☐Single	☐Full-Time	☐Full-Time
☐Female	☐Lesbian, gay, or homosexual	☐Married	☐Part-Time	☐Part-Time
☐Female-to-Male/Transgender Male	☐Bisexual	☐Divorced	☐Not a student	☐Not Employed
☐Male-to-Female/Transgender Female	☐Something else	☐Widowed		☐Retired
☐Other	☐Don't know			
☐Choose not to disclose	☐Choose not to disclose			

Housing Status: Are you Homeless?☐Yes ☐No If homeless, are you: ☐Doubling up ☐Shelter ☐Street ☐Transitional ☐Unknown	Gross Household Income: $ _____☐ Monthly ☐Annually # Adults & Children (Under 18) In Household: _____	Military Veteran? ☐ Yes ☐ No	Migratory or Seasonal Agricultural Worker? ☐ Yes ☐ No

GUARANTOR (Person to Be Billed, Check here if same as patient ☐) *

Last Name:	First Name:	MI:	Date of Birth:	Social Security Number:

Street Address:	City:	State:	Zip Code:	County:

MEDICAL INSURANCE

Insurance Company	Policy Holder Name	Relationship to patient	DOB	M/F	Employer	Zip Code

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE *

Assignment of Insurance Benefits, Release of Information and Authorization of Treatment.
I the undersigned authorize my insurance benefits to be paid directly to the provider of Bartz-Altadonna Community Health Center for services render. I understand that I am ultimately financially responsible for any balance due for approved and covered charges not paid by insurance. I hereby authorize BACHC to release all information necessary to secure the payment of insurance benefits. I authorize the use of this signature on all my insurance claim submissions. I understand that payment is expected at the time services are rendered. A copy of this is as valid as the original.

Patient/Guardian Signature:_____ **Date:**_____

Relationship to patient_____ **(Write "SELF" if you are the patient)**

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Internal Use:

Date Received: _____/_____/_____

Staff Initials: _____

Consent and Acknowledgment Summary Form

_____ * **Initial**

Consents and Acknowledgements
By initialing, you confirm receiving and understanding BACHC's "**Consents and Acknowledgements**," "**Patient Rights and Responsibilities**," and "**Notice of Privacy Practices**." This entails consenting to care, acknowledging patient rights and responsibilities, understanding health information use, and acknowledging financial obligations and the Sliding Fee Scale option.

_____ * **Initial**

Patient Acknowledgement of Financial Obligation
By initialing, you acknowledge your financial responsibilities at Bartz-Altadonna Community Health Center, including covering care costs, providing reimbursement details, and applying for discounts if eligible. You agree to assist with insurance/benefit applications, pay co-payments and fees at service time, and recognize your self-pay obligations if uninsured.

_____ **Initial**

Advanced Directive Offer Attestation (Only for 18 years or Older)
By initialing, I confirm being informed by Bartz-Altadonna about advance directives, which let me state my end-of-life care preferences. I understand my right to make or refuse an advance directive anytime. This attests to receiving this information and understanding my rights.

_____ * **Initial**

HIPAA Authorization
By initialing, you confirm understanding Bartz-Altadonna CHC's HIPAA Authorization Privacy Policy, permitting BACHC to share your health information for treatment, payment, and healthcare processes as outlined in the Privacy Notice. You may designate authorized recipients of your medical information. This consent is revocable, with prior disclosures unaffected. **List below any individuals authorized to access your medical details.**

PERSONS AUTHORIZED TO OBTAIN MEDICAL INFORMATION *

Patient Name: _____If patient under 18 or has guardian, name of guardian: _____

I, _____, authorize Bartz-Altadonna Community Health Center to share my health and/or billing information with the individuals listed below, who are involved in my care or its payment. I understand BACHC is not liable for the shared information once it's given to those I have named. Providing Date of Birth is required for identity verification by the office.

Name:	Relationship:	Phone:	Date of Birth:

ONLY FILL FOR MINORS

This Section grants Bartz-Altadonna Community Health Center permission to treat minors (under 18) for nonurgent medical care during visits accompanied by someone other than their parent or legal guardian.

PERMSSION FOR NONURGENT PEDIATRIC CARE

I, _____, as parent/legal guardian, authorize the adults listed below to make nonurgent medical decisions for my minor child _____, born on _____. I confirm my legal authority to grant this permission to those at least 18 years old and legally competent. I acknowledge that my child's protected health information may be disclosed to these individuals.

NAME OF PERSON authorized to make medical care decisions for mychild. (Print clearly)	RELATIONSHIP TO CHILD:

LIMITATIONS: The listed person(s) can consent to any required care, except for any treatments you specify as prohibited below. Please list any care you do not authorize in the box to the right.	List of Prohibited Treatments:

By signing below, you confirm agreement with all documents you've initialed at Bartz-Altadonna CHC, including "Consents and Acknowledgements," "Patient Rights and Responsibilities," "Notice of Privacy Practices," "Advanced Directive Offer Attestation ," "Financial Obligation Acknowledgement," "HIPAA Authorization," and (if applicable) "Permission for Nonurgent Pediatric Care." You also permit BACHC to use and disclose your health information as per Federal Privacy Standards and understand your HIPAA rights regarding the use of this information for treatment, payment, and healthcare operations.

Patient Signature: *	Patient Printed Name: *	Date: *

If this page is being signed by a personal representative, please fill out the information below:

Signature of Personal Representative or Guardian	Personal Representative or Guardian Name:	Date:

Authority of Personal Representative to Sign for Patient (check one): ☐ **Parent** ☐ **Guardian** ☐ **Power of Attorney** ☐ **Other:** _____

BACHC
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Records should be faxed to BACHC at (866) 572-7851

Authorization to Release or Request Health Information

PATIENT INFORMATION *		
Patient Name:		Date of Birth:
Address:		
Phone Number:	Email:	Date of Request:

INFORMATION TO RELEASE/REQUEST FROM

I Authorize BACHC to release/request medical records

☐ Release to: _____

☐ Request From: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

Purpose of this request: ☐ **Transfer of care** ☐ **Insurance Personnel** ☐ **School** ☐ **Legal** ☐ **Other:**_____

Request Complete Medical Record or Preventative Care Records: By initialing here, you authorize BACHC to retrieve your complete medical record history or preventive care records. This will assist in understanding and optimizing your care.

_____ * **Initial**

☐Preventative Care Records ☐Complete Medical Record

Specific Information to Release/Request:

☐History and Physical Report	☐EKG/ECHO	☐Pathology Report	☐Laboratory Report	☐Radiology Report
☐Operative Report	☐Discharge Summary	☐Consultation Report	☐Emergency Report	☐Billing Record
☐ Entire Record	☐Treatment	☐Diagnosis	☐Assessment/Evaluation	☐ Visit Notes

☐Other: _____ Treatment Dates: _____to _____

Records may include information related to alcohol or drug use and HIV or AIDS. However, treatment records from drug and alcohol facilities or results of HIV test will not be disclosed unless specifically requested. Mental health and behavioral health information if marked will require a seperate authorization.

☐ HIV Information ☐Drug/Alcohol Treatment Information ☐Mental/Behavioral Health Information

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

- **Right to Receive a Copy of Authorization - I understand that if I agree to sign this Authorization, which I am not required to do, I can request a copy of the signed form.**
- **Right to Revoke Authorization - I understand that I have the right to revoke this Authorization at any time by notifying BACHC in writing. I may use the Revocation of Authorization at the bottom of this form and mail or deliver the revocation to address listed within the Revocation.**

Authorization to Release or Request Health Information

Records should be faxed to BACHC at (866) 572-7851

YOU ARE REQUIRED TO READ AND SIGN BELOW. I UNDERSTAND THAT:

- **I understand that the health center will not deny me treatment because I refuse to sign this Authorization.**
- **I understand that I may revoke this Authorization at any time by signing below the "revocation of authorization" or inform BACHC in writing, unless the health center has already taken action based on this Authorization, or unless this Authorization is given as a condition of obtaining insurance coverage and the insurer has certain legal rights to contest the policy or a claim under the policy.**
- **I understand that this Authorization is valid for a one-year period from the date of my signature below, but that the information disclosed based on this Authorization may be re-disclosed by the entity or the person who receives the information. Once disclosed, it is possible that the information will no longer be protected under Federal or State privacy laws.**
- **I may inspect or copy the medical information that is being released, used and/or shared pursuant to this Authorization Form.**
- **The use or disclosure of information obtained or released pursuant to this Authorization may result in direct or indirect payment to BACHC from a third-party, including copying fees.**
- **I understand that the use or disclosure of HIV-related and drug/alcohol treatment is highly sensitive and requires the specific authorization I have provided by marking the boxes above. A separate authorization form would need to be completed if I were to request to see my own Mental/Behavioral Health Information.**
- **I understand that if the records or information being released involve treatment for alcohol or substance addiction, my records are also protected by Federal law and regulations relating to "confidentiality of alcohol or drug abuse patient records,"(42 C.F.R. Part 2, 42 U.S.C. § 290dd-2).**
- **I understand that there may be a charge for the requested records.**

Signature: *	**Printed Name:** *(If other than patient, print relationship)* *	**Date:** *

BACHC understands the importance of your request and strives to process your request as soon as possible in the order in which your request was received. Please let us know if the requested information is needed by a specific date and every effort will be made to meet your needs. BACHC complies with HIPAA regulations which require processing of requests for medical information within 30 business days of request.

NOTE TO INDIVIDUAL OR ENTITY AUTHORIZED TO RECEIVE ALCOHOL OR SUBSTANCE ABUSE ADDICTION RECORDS Pursuant to This Notice: This information has been disclosed to you from records protected by Federal Confidentiality Rules (42 CFR Part 2) relating to the confidentiality of alcohol and substance abuse records. Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. Federal rules also restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse client of BACHC.

REVOKE THIS AUTHORIZATION FORM

As part of the revocation process, we must inform you about the potential impact on your healthcare if you do not provide authorization to release medical information.

Key Implications:

- **Delays in Treatment: Without access to your comprehensive medical history, there could be significant delays in diagnosis and treatment.**
- **Limited Coordination with Other Providers: Our ability to communicate and collaborate with other healthcare professionals may be hindered, affecting the quality of your care.**

We urge you to consider these implications carefully. If you have any concerns or need further clarification, please contact us immediately.

REVOCATION OF AUTHORIZATION

Name of Patient:	**Signature of Patient/ Legal Representative:**	**Date:**

Contact person:	**Facility Name:**	**Phone Number:**
Address:		

If signed by someone other than the patient, print name and state relationship and authority

Name of Representative:	**Relationship and Authority:**

HIPAA Authorization Privacy Policy

Bartz-Altadonna Community Health Center (BACHC) has taken measures to protect all of our patients' private medical information. BACHC will not release any information to anyone unless you have provided the requested information below. These would be people other than what is covered in our Notice of Privacy Practices.

Your protected health information will be used by BACHC or disclosed to others for the purpose of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice. Please review the Notice of Privacy Practices for a more complete description of how your protected health information may be used or disclosed. You may review the notice and request a copy of the Notice of Privacy Practices for your own records. See the Client Services Representative to receive a copy.

You may request a restriction on the use or disclosure of your protected health information. BACHC may or may not agree to restrict the use or disclosure of your protected health information. If BACHC agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the Federal Privacy Standards.

You may revoke this consent to the use and disclosure of your protected health information. You must revoke consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Consents and Acknowledgements

In order for you to become a patient, we need your consent to provide you with care.We also need you to acknowledge that we have provided you with certain important information and documents. If you have any questions about any of this information or need help completing this form, please do not hesitate to ask a member of our staff. It is important to us that you feel comfortable with all of this information. By signing and initialing consent form, you are indicating that you understand the information, have been given a chance to ask questions, and are giving your consent.

GENERAL CONSENT TO TREAT

I voluntarily agree to receive services from BACHC and authorize the providers of BACHC to provide such care, treatment, or services as are considered necessary and advisable for me. I understand that I should participate in the planning for my care and that I have a right to refuse interventions, treatment, care, services or medications at any time to the extent the law allows. I know that the care I will receive may include tests, injections, and other medications, etc., that are based on established medical criteria, but not free of risk. Finally, I know that BACHC sometimes has students/residents being trained as doctors, nurses, therapists and other health care providers who might be helping to care for me. These students are under the supervision of licensed providers.

I understand that BACHC is committed to involving me in my care and that no one can be given care at BACHC without agreeing to the care unless there is an emergency. If there is an emergency, I know that someone at BACHC may help me without waiting for me to say okay. I understand that some services require me to sign another Informed Consent to Treatment, so I may be asked to complete that later.

NOTICE OF PRIVACY PRACTICE

I have been given a copy of BACHC's Notice of Privacy Practices and I understand that BACHC is required by law to protect my personal health information. I have had the chance to ask questions about BACHC's Notice of Privacy Practices and feel comfortable with the protections that it offers me. I understand that there are times when the law allows my personal health information to be shared with individuals or entities outside of BACHC, including but not limited to for treatment, payment and operations purposes, when required by law, and in connection with the mandatory reporting of certain diseases.

INTEGRATED MODEL OF CARE

BACHC offers a wide variety of services to its clients. I understand that in order for me to get the best service for my needs, programs within BACHC may share information concerning my health to ensure the quality and continuity of my care across service areas.

HEALTH INFORMATION EXCHANGE

I understand that BACHC participates in certain health information exchanges with other hospitals and health centers located in the Antelope Valley and surrounding areas. Your health information may be shared with these exchanges to provide faster access, better coordination of care, and to assist providers and public health officials in making more informed decisions. Please notify BACHC if you wish to "opt-out" and disable access to your health information, except to the extent that disclosure of such information is permitted or mandated by law.

PATIENT RIGHTS AND RESPONSIBILITIES

I have been given a copy of the BACHC Patient Rights and Responsibilities document and understand that both the Rights and the Responsibilities laid out in that document must govern my interactions at BACHC. I also understand that BACHC and I are responsible for adhering to the Rights and Responsibilities. I understand that I have a right to file a complaint or grievance with BACHC, as described in BACHC's Patient Handbook. The Patient Handbook contains information about being a patient at BACHC, including services that BACHC offers, hours of operation, and contact information for services.

RELEASE OF INFORMATION FOR BILLING AND CONSENT TO REIMBURSE

I know that BACHC needs to send parts of my personal health information to organizations that help pay for my care, such as my insurance company or an organization that grants money to BACHC. I allow BACHC to release the relevant parts of my records so that my care can be paid for. If I do not feel comfortable with this, then I understand that I can request a higher level of privacy protection than is afforded tome under the Health Insurance Portability and Accountability Act (HIPAA).

ACKNOWLEDGMENT OF DUTY TO REIMBURSE BACHC FOR HEALTH CARE SERVICES

I understand that BACHC offers a Sliding Fee Scale of discounted or free health care items and services to individuals who are deemed unable to pay based on their level of income. In order to be eligible for BACHC's Sliding Fee Scale of discounted or free services, I will need to provide BACHC's Client Services team with documents establishing that I meet income eligibility requirements. If I do not provide the required documents to BACHC, I am responsible for paying my fees for medical and behavioral health at BACHC in full at the time of service

Patient Acknowledgement of Financial Obligation

Bartz-Altadonna Community Health Center ("BACHC") is a Federally Qualified Health Center that is subject to Section 330 of the Public Health Service Act. Section 330 specifies that Health Centers must assure that no patient will be denied services due to their inability to pay for such services. It also requires Health Centers to adopt written policies and procedures to maximize collections and reimbursement for their costs in providing health services.

I UNDERSTAND THAT I AM RESPONSIBLE FOR:

- Contributing to the cost of my care and treatment as my health insurance coverage requires and based on my ability to pay;
- Providing BACHC with the information it needs to receive reimbursement for the treatment or services it provides to me;
- Requesting consideration for discounted fees under BACHC's Sliding Fee Scale based on my level of income, and providing documentation to support eligibility for discounted fees that may be requested by BACHC's Registration and Benefits team;
- Assisting the Registration and Benefits team with any application for insurance or public benefits that I may be entitled to;
- Paying my co-payment (if applicable) when I check-in for my appointment and paying my deductible or any other fees that may be owed at the conclusion of the medical visit;
- Paying my fees for medical and behavioral health received at BACHC in full at the time of service, either upon check-in or at check-out as requested by BACHC if I have been deemed a self-pay patient based on the fact that I have insurance coverage that BACHC does not accept but have elected to remain in care at BACHC.

Patient Rights and Responsibilities Statement

AS A BACHC PATIENT, YOU HAVE THE RIGHT TO:

ACCESS SERVICES in a safe and respectful manner

- Receive services at BACHC regardless of your race, color, religion, sex, marital status, sexual orientation, gender identity or expression, English language proficiency, national origin, age, disability, veteran status, or any other status protected by law.
- Receive respect and consideration from every employee, volunteer or trainee you interact with at BACHC.
- Feel safe from harm and free from verbal, physical, or psychological abuse, intimidation or harassment when you are at BACHC's facilities.

PRIVACY regarding your personal health information

- Expect BACHC to comply with the Federal and State privacy laws when using or disclosing information about you or the health care and related services you receive at BACHC.
- Receive a copy of BACHC's Notice of Privacy Practices when you register as a new patient so that you will be more fully informed about your privacy rights.
- Active involvement in your ongoing care
- Help BACHC providers and staff to develop a plan for the treatment and services you receive at BACHC.
- Provide (or withhold) your consent to voluntary treatment, including your participation in clinical research, and be informed about the consequences of refusing any treatment or service.
- Provide BACHC staff members with positive or negative feedback about your care or voice your concerns or complaints about the Health Center.

TIMELY INFORMATION about your care

- Receive complete information about your diagnosis, and treatment or service plan in plain language that you can understand. Obtain a copy of your medical records upon request unless the law permits BACHC to withhold the records.
- Receive an explanation of the costs associated with your care at BACHC.
- Obtain assistance with referrals to other providers.

QUALITY SERVICES from our health center

- Receive coordinated health care treatment and services consistent with professional standards.
- Receive services from licensed and credentialed BACHC providers.
- Request BACHC to provide hearing, language, literacy or other communication assistance required by law.
- Receive services and care in the least restrictive environment feasible, free from chemical or physical restraints.

AS A BACHC PATIENT, YOU ARE RESPONSIBLE FOR:

YOUR PERSONAL INTERACTIONS with our health center team

- Treat BACHC employees, volunteers, trainees, contractors, other patients, and guests with respect at all times.
- Do not make any threatening or offensive statements at BACHC's facilities.
- Do not engage in any act of physical violence or other threatening or inappropriate behavior at BACHC's facilities.
- Do not distribute or use alcohol or drugs on BACHC's property or enter a BACHC facility or program under the influence of illegal drugs or alcohol.

ACTIVE ENGAGEMENT in your care

- Take an active part in your treatment or service plan at BACHC and stay in contact with your providers about your care.
- Request any hearing, language, literacy or other communications assistance you may need at least 48 hours prior to your visit.
- Show up for your appointments at least 15minutes ahead of schedule and provide advance notice whenever it becomes necessary to cancel an appointment at BACHC.
- Contribute to the cost of your care that the law or the health plan that you participate in require you to pay.

TIMELY INFORMATION sharing

- Provide BACHC with complete, accurate, and truthful information at all times.

BACHC's Patient Rights and Responsibilities Policy grants BACHC discretion to take action placing limits on a patient's ability to receive treatment or services at BACHC based on a patient's failure to meet their Responsibilities or for any other reason permitted by law. Likewise, any BACHC patient has discretion to decide not to seek further treatment or services at BACHC based on BACHC's failure to abide by the patient Rights set forth in this Statement or for any other reason.

If you believe your rights as a Bartz-Altadonna CHC patient have been violated...
please contact our Chief of Compliance at: (661) 874-4050

Notice of Privacy Practices

This Notice describes how medical information about you may be used and disclosed by Bartz-Altadonna Community Health Center (BACHC) and how you can get access to this information. Please review it carefully.

YOUR RIGHTS
You have the right to:
- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communications
- Ask us to limit the information about you that we share
- Get a list of those with whom we've shared your information
- Get a copy of this Notice of Privacy Practices
- Choose someone to act as your personal representative for purposes of your health information
- File a complaint if you believe your privacy rights have been violated

YOUR CHOICES
You have some choices in the way that we use and share information as we:
- Tell family and friends about your health
- Provide disaster relief
- Provide mental health care
- Market our services
- Raise funds

OUR USES AND DISCLOSURES
We may use and share your information as we:
- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

A more detailed description of your rights, your choices and our uses and disclosures of your health information is set forth below:

YOUR RIGHTS
When it comes to your health information, you have certain rights. This section of our Notice of Privacy Practices explains your rights and some of our responsibilities under the law.

Get an electronic or paper copy of your medical record.
- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
- You can ask us to correct health information about you that you think is incorrect or incomplete.

Ask us to amend your medical record
- We may say "no," but we'll tell you why in writing within 60 days.

Request confidential communications
- Make a reasonable request to contact you in a specific way (for example, home or office phone) or to send mail to a different address

Ask us to limit what we use or share
- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information
- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this Notice of Privacy Practices
- You can ask for a paper copy of this Notice at any time, even if you have agreed to receive the Notice electronically and we will provide you with a paper copy promptly.

Choose someone to act for you
- If you have given someone health care power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- Our Legal Services Department can assist you with the preparation of a health care power of attorney document that provides authority for another person to act on your behalf.

File a complaint if you feel your rights are violated
- You can complain if you feel we have violated your rights by contacting Bartz-Altadonna CHC at (661)874-4050.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, SW, Washington, DC 20201, calling 1.877.696.6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints.
- We will not retaliate against you for filing a complaint

YOUR CHOICES
For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions. In these cases, you have both the right and choice to tell us to:
- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

Notice of Privacy Practices (Continued)

In these cases we generally do not share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

OUR USES AND DISCLOSURESOF INFORMATION ABOUT YOU

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

To treat you

We can use your health information and share it with other professional who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

To run our organization

We can use and share your health information to run our health center, improve your care, and contact you when necessary.

Example: We use health information about you to improve the quality of care we provide to you and others.

In order to bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We can give information about you to your health insurance plan in order to be paid for the services you receive at the health center.

HOW ELSE CAN WE USE OR SHARE YOUR HEALTH INFORMATION?

We are allowed or required to share your information in other ways—usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. If you want to learn more you can go to:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Work with a medical examiner or funeral director

We can share health information about a deceased patient with a coroner, medical examiner, or funeral director

Address workers' compensation, law enforcement, and other government requests.

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

OUR RESPONSIBILITIES

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know in writing if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this Notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.
- We do not share records relating to your participation in a BACHC substance abuse program or your mental health records with providers outside of BACHC without your written authorization.

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

BACHC is participating in the regional Health Information Exchange (HIE). The HIE is a way of sharing your health information among participating doctors' offices, hospitals, labs, radiology centers, hospitals and other providers through secure, electronic means. Participating in the HIE permits our medical providers to better coordinate the health care you receive, but you have the right to optout of the HIE at any time.

Acknowledgement of receipt of this Notice of Privacy Practices is indicated by your signature on our Informed Consent Form that is scanned into your electronic medical record.