NEW PATIENT REGISTRATION

NORTHWEST SPECIALTY HOSPITAL
QUALITY CARE SINCE 2009 | PROUDLY OWNED AND OPERATED BY PHYSICIANS

1) Full Legal Name			Previous Last Name
Last	First	M.I.	

2) Gender	Social Security Number	Date of Birth
❑ Female ❑ Male ❑ Unknown ❑ Other _____		
Martial Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed		

3) Mailing Address			
Street or PO Box	City	State	Zip Code

4) Contact Information (Please check your preferred contact number)			
❑ Cell phone	❑ Home phone	❑ Work Phone	❑ Email

5) Employer			
Name		Phone	
Street	City	State	Zip Code

6) Preferred Pharmacy			
Name		Phone	
Street	City	State	Zip Code

7) Emergency Contact		
Name	Relationship	Phone

8) Primary Care Provider		
Name	Address	Phone

9) Referring Provider (If Applicable)		
Name	Address	Phone

10) Guarantor			
Last	First		M.I.
Street or PO Box	City	State	Zip Code
SSN	Phone	Relationship to patient	

11) Insurance Information			
Primary Insurance Company Name	ID#	Group#	Phone
Subscriber-Employee Name	SSN	DOB	Relationship to patient
Secondary Insurance Company Name	ID#	Group#	Phone
Subscriber-Employee Name	SSN	DOB	Relationship to patient

12) Demographic Information

❑ Decline ❑ White ❑ Native Hawaiian or Other Pacific Islander ❑ Black or African American
❑ Other _____

13) Ethnic Information

❑ Declined ❑ Not Hispanic or Latino ❑ Hispanic or Latino

14) Preferred Language

❑ English ❑ French ❑ Russian ❑ Arabic ❑ German ❑ Spanish ❑ Chinese ❑ Japanese
❑ Vietnamese ❑ Other _____

I hereby authorize any insurance benefits to be paid directly to Northwest Specialty Hospital. I understand that I am responsible for paying non-covered services. I hereby authorize the release of pertinent medical information to my insurance carriers and to such other organizations as may be permitted under the Health Insurance Portability and Accountability Act (HIPAA). I have verified that demographics information sheet to be true and correct.

_____

Signature (Patient or Guardian) Date

_____

Relationship to patient

NORTHWEST SPECIALTY HOSPITAL

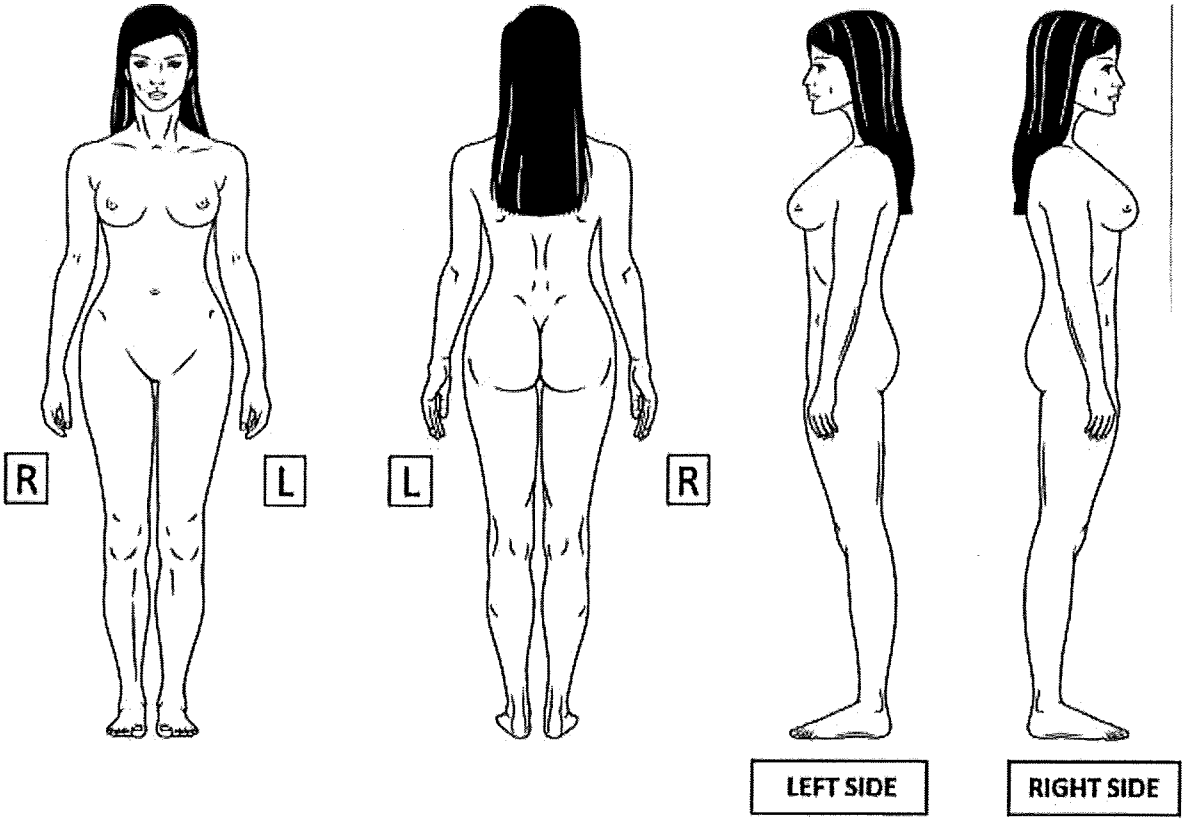
NEW PATIENT PELVIC PAIN QUESTIONNAIRE

WOMEN'S CARE

REASON FOR VISIT TODAY	

PLEASE MARK WHERE YOUR PAIN IS. USE THE SYMBOLS TO INDICATE WHAT TYPE OF PAIN YOU EXPERIENCE IN EACH AREA.

ACHING	BURNING	NUMBNESS	PINS AND NEEDLES	STABBING
ΔΔΔΔΔΔΔ	XXXXXXX	=======	OOOOOOO	///////



NEW PATIENT PELVIC PAIN QUESTIONNAIRE

WOMEN'S CARE

PAIN LEVEL

IN THE PAST 30 DAYS PLEASE INDICATE YOUR PAIN LEVEL BASED ON THE SCALE BELOW.

TODAY	0	1	2	3	4	5	6	7	8	9	10
BEST DAY	0	1	2	3	4	5	6	7	8	9	10
WORST DAY	0	1	2	3	4	5	6	7	8	9	10

SCALE

0 = NO PAIN
1 = VERY MILD PAIN: YOU ARE AWARE OF THE PAIN BUT IT DOESN'T BOTHER YOU
2 = MILD PAIN THAT YOU CAN TOLERATE WITHOUT TAKING MEDICATION
3 = MILD TO MODERATE PAIN THAT REQUIRES MEDICATION TO TOLERATE
4-5 = MODERATE PAIN THAT SOMETIMES IS NOT CONTROLLED AND CAUSES YOU TO FEEL ANTISOCIAL
6 = FAIRLY SEVERE PAIN THAT INTERFERES WITH DAILY LIFE
7-9 = INTENSELY SEVERE PAIN
10 = WORST PAIN IMAGINABLE

HOW DID THIS PAIN BEGIN?			
☐ AUTO ACCIDENT	☐ AT WORK	☐ AT HOME	☐ FOLLOWING SURGERY
☐ AFTER AN ILLNESS – TYPE?			
☐ OTHER/UNKNOWN:			

IF ACCIDENT OR INJURY CAUSED YOUR PAIN, PLEASE BRIEFLY DESCRIBE

WHEN DID THE PAIN BEGIN? WHAT WAS THE DATE OF YOUR INJURY?

HAVE YOU EVER HAD THIS PAIN BEFORE?	
☐ YES	☐ NO
IF YES HOW LONG AGO?	

NEW PATIENT PELVIC PAIN QUESTIONNAIRE

WOMEN'S CARE

HAVE YOU SEEN ANY OTHER PHYSICIAN FOR THIS PAIN?	
☐ YES ☐ NO	
PHYSICIAN NAME	
SPECIALTY	
HAVE ANY LEGAL CLAIMS BEEN FILED RELATED TO YOUR PAIN?	
☐ YES ☐ NO	

HOW OFTEN DO YOU HAVE PAIN?	
☐ CONSTANTLY (100% OF THE TIME)	☐ INTERMITTENTLY (50% OF THE TIME)
☐ FREQUENTLY (75% OF THE TIME)	☐ OCCASIONALLY (25% OF THE TIME)

WHAT MAKES THE PAIN FEEL BETTER?			
☐ WALKING	☐ LEANING FORWARD	☐ RELAXATION	☐ HEAT
☐ LYING FLAT	☐ LYING WITH HIP/KNEES BENT	☐ REST	☐ SPINAL CORD STIMULATOR
☐ INTRATHECAL PUMP			

WHAT MAKES THE PAIN WORSE?		
☐ STANDING	☐ LAYING DOWN	☐ BOWEL MOVEMENTS
☐ SITTING	☐ LIFTING	☐ COUGHING/SNEEZING
☐ GETTING OUT OF BED	☐ BENDING FORWARD	☐ DAMP WEATHER
☐ WALKING	☐ BENDING BACKWARD	☐ RISING OUT OF A CHAIR
☐ COLD	☐ URINATION	☐ EXERCISE
☐ OTHER:		

WHICH TREATMENTS HAVE YOU TRIED BEFORE?		
☐ REST/ACTIVITY MODIFICATION	☐ ACUPUNCTURE	☐ CHIROPRACTOR VISITS
☐ STEROID/CORTISONE INJECTIONS	☐ HEAT THERAPY	☐ PHYSICAL THERAPY
☐ ELECTRICAL STIMULATION (TENS)	☐ NERVE BLOCK	☐ MASSAGE THERAPY
☐ BIOFEEDBACK	☐ PSYCHOTHERAPY	☐ SURGERY
☐ OTHER:		

DO YOU HAVE ANY OF THE FOLLOWING SYMPTOMS?		
NUMBNESS	BLADDER INCONTINENCE	WEAKNESS IN ARM/LEG
TINGLING	BOWEL INCONTINENCE	JOINT SWELLING

NEW PATIENT PELVIC PAIN QUESTIONNAIRE

WOMEN'S CARE

HAVE YOU HAD ANY OF THE FOLLOWING STUDIES?		
☐ MRI	☐ X-RAY	☐ CT SCAN
☐ BONE SCAN	☐ OTHER:	

MEDICATIONS USED	WHY / PRESCIBING PHYSICIAN:
☐ ACETAMINOPHEN (TYLENOL)	
☐ ASPIRIN	
☐ IBUPROFEN (ADVIL)	
☐ NAPROXEN (ALEVE)	
☐ ORAL STEROIDS (MEDROL DOSE PACK)	
☐ OPIOID (NARCOTIC)	
☐ AGGRENOX	
☐ COUMADIN (WARFARIN)	
☐ PRADAXA (DABIGATRAN)	
☐ XARELTO (RIBAROXABAN)	
☐ PLAVIX (CLOPIDOGREL)	
☐ LOVENOX (ENOXAPARIN)	
☐ PREGABALIN (LYRICA)	
☐ GABAPENTIN (NEURONTIN)	
☐ ANTIDEPRESSANT	
☐ OTHER ?	

ARE YOU ALLERGIC TO:			
☐ IODINE	☐ SHELLFISH	☐ LATEX	☐ OTHER

SOCIAL HISTORY			
DO YOU SMOKE?	☐ YES ☐ NO	PACKS/DAY	YEARS
ALCOHOL USE?	☐ YES ☐ NO	DRINKS/DAY	
OTHER SUBSTANCES?	☐ YES ☐ NO	LIST:	LAST USED:

NEW PATIENT PELVIC PAIN QUESTIONNAIRE

NORTHWEST SPECIALTY HOSPITAL

WOMEN'S CARE

PAST FAMILY HISTORY		
☐ HIGH BLOOD PRESSURE	☐ HEART DISEASE	☐ DIABETES
☐ NEUROLOGICAL DISEASE	☐ DEPRESSION/ANXIETY	
☐ CANCER (TYPE):	☐ BIPOLAR DISORDER	☐ OTHER:

PAST MEDICAL HISTORY		
☐ HIGH BLOOD PRESSURE	☐ HEART DISEASE	☐ DIABETES
☐ NEUROLOGICAL DISEASE	☐ DEPRESSION/ANXIETY	☐ GASTRIC REFLUX
☐ CANCER (TYPE):	☐ BIPOLAR DISORDER	☐ OTHER:

SURGICAL HISTORY: PLEASE LIST			
SURGERY		DATE	
SURGERY		DATE	
SURGERY		DATE	

DO YOU HAVE A FAMILY HISTORY OF?		
☐ ALCOHOL ABUSE	☐ ILLEGAL DRUG USE	☐ PRESCRIPTION DRUG ABUSE
WHO:	☐ FATHER ☐ MOTHER ☐ CHILD ☐ SIBLING	

DO YOU HAVE A PERSONAL HISTORY OF?		
☐ ALCOHOL ABUSE	☐ ILLEGAL DRUG USE	☐ PRESCRIPTION DRUG ABUSE
DID YOU SEEK PROFESSIONAL TREATMENT OR DETOXIFICATION?		
☐ YES ☐ NO		

DO YOU HAVE A DIAGNOSIS OF?		
☐ ADD/ADHD	☐ OCD	☐ BIPOLAR
☐ SCHIZOPHRENIA	☐ DEPRESSION	☐ OTHER:
ARE YOU ON MEDICATION FOR ANY OF THE ABOVE?		
MEDICATION NAME(S):		

DO YOU HAVE A HISTORY OF PRE-ADOLESCENT SEXUAL ABUSE?
☐ YES ☐ NO

PLEASE INDICATE YOUR EMPLOYMENT STATUS:		
☐ UNEMPLOYED BECAUSE OF PAIN	☐ ON DISABILITY	☐ EMPLOYED, PART-TIME
☐ UNEMPLOYED BUT LOOKING FOR WORK	☐ RETIRED	☐ EMPLOYED, FULL-TIME
☐ HOMEMAKER	☐ OTHER:	
JOB DESCRIPTION:		

NEW PATIENT PELVIC PAIN QUESTIONNAIRE

WOMEN'S CARE

NORTHWEST SPECIALTY HOSPITAL

DO YOU CURRENTLY HAVE? (IF YES, CHECK APPROPRIATE BOXES)

GENERAL
- ☐ Fatigue
- ☐ Fever
- ☐ Weight Gain
- ☐ Weight Loss

RESPIRATORY
- ☐ Chronic Cough
- ☐ Decreased Exercise Tolerance
- ☐ Difficulty Breathing
- ☐ Coughing Up Blood
- ☐ Sputum Production
- ☐ Wheezing

GENITOURINARY
- ☐ Vaginal Discharge
- ☐ Menstrual Irregularities
- ☐ Difficulty Starting/Stopping (Urinary Stream)
- ☐ Painful Urination
- ☐ Change in Urinary Stream
- ☐ Increased Frequency
- ☐ Blood in Urine
- ☐ Loss of Bladder Control
- ☐ Nighttime Urination
- ☐ Urinary Discharge
- ☐ Impotence
- ☐ Penile Lesions
- ☐ Testicular Mass
- ☐ Testicular Pain

NEUROLOGICAL
- ☐ Loss of Bowel Control
- ☐ Dizziness
- ☐ Vertigo
- ☐ Headaches
- ☐ Numbness
- ☐ Tingling
- ☐ Passing Out
- ☐ Seizures
- ☐ Tremor

SKIN
- ☐ Nail Changes
- ☐ New Lesions
- ☐ Rash
- ☐ Skin
- ☐ Skin Color Changes

BREAST
- ☐ Breast Mass
- ☐ Breast Pain
- ☐ Nipple Discharge
- ☐ Skin Changes

PSYCHIATRIC
- ☐ Anxiety
- ☐ Change in Sleep Pattern
- ☐ Depression
- ☐ Hallucinations
- ☐ Suicidal Thoughts

HEENT
- ☐ Double Vision
- ☐ Eye Pain
- ☐ Eye Redness
- ☐ Decreased Hearing
- ☐ Nose Bleeds
- ☐ Dry Mouth
- ☐ Hoarseness
- ☐ Oral Ulcers
- ☐ Sore Throat

CARDIOVASCULAR
- ☐ Chest Pain
- ☐ Leg Pains with Walking
- ☐ Leg Swelling
- ☐ Night Awakening (due to trouble breathing)
- ☐ Palpitations
- ☐ Shortness of Breath

MUSCULOSKELETAL
- ☐ Decreased Range of Motion
- ☐ Joint Pain
- ☐ Joint Redness
- ☐ Joint Swelling
- ☐ Joint Stiffness
- ☐ Muscle Wasting
- ☐ Muscle Weakness
- ☐ Muscle Aches/Pains

ENDOCRINE
- ☐ Appetite Changes
- ☐ Cold Intolerance
- ☐ Increased Thirst
- ☐ Increased Urination
- ☐ Hair Changes

NECK
- ☐ Neck Pain
- ☐ Swollen Glands

GASTROINTESTINAL
- ☐ Abdominal Pain
- ☐ Change in Bowel Habits
- ☐ Constipation
- ☐ Diarrhea
- ☐ Nausea
- ☐ Vomiting
- ☐ Rectal Bleeding
- ☐ Trouble Swallowing

HEMATOLOGY
- ☐ Easy Bruising
- ☐ Enlarged Lymph Nodes
- ☐ Prolonged Bleeding

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE

NORTHWEST SPECIALTY HOSPITAL
QUALITY CARE SINCE 2003 | PROUDLY OWNED AND OPERATED BY PHYSICIANS

Women's Care

I, _____ acknowledge that I have been offered/received a copy of the Privacy Notice.

In addition to our normal operational disclosures of privacy information, please identify to whom we may release your health care information. Each name must be identified. These should be people who help you with your health care needs and may need to be knowledgeable about your condition, treatment, and options. It is still the responsibility of the party or parties listed below to request this information:

NAME	RELATIONSHIP
NAME	RELATIONSHIP
NAME	RELATIONSHIP
NAME	RELATIONSHIP

PRINTED PATIENT NAME _____ SIGNATURE PATIENT OR REPRESENTIVE _____ DATE _____

For Facility use only:

If not signed, reason why acknowledgement was not obtained: _____

Staff Witness seeking acknowledgement

NAME _____ DATE _____

NOTICE OF PHYSICIAN OWNERSHIP

NORTHWEST SPECIALTY HOSPITAL

Northwest Specialty Hospital is a federally recognized "physician owned" specialty hospital. As a patient you have the right to receive a list of all of the physician owners in this hospital, upon request. Your physician may or may not have an ownership interest in Northwest Specialty Hospital, as not all physicians who practice here have an ownership interest. If you feel that the services that have been ordered for you are not proper or are negatively impacted by physician ownership in the facility, please notify a member of the administration immediately. Our Chief Nursing Officer can be reached by calling (208) 262-2300.

You should be aware that alternative health care facilities may be available to you.

Please sign below to acknowledge your receipt and understanding of this disclosure and that you have had an opportunity to ask and receive answers to any questions you may have about this disclosure, including your options, if any, for treatment at other facilities.

PATIENT NAME	PATIENT SIGNATURE	DATE
WITNESS NAME	WITNESS SIGNATURE	DATE

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.

This Privacy Notice is being provided to you as a requirement of a federal law, the Health Insurance Portability and Accountability Act (HIPAA). This Privacy Notice describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information in some cases. Your "protected health information" means any written, electronic or oral health information about you, including demographic data that can be used to identify you. This is health information that is created or received by your health care provider, and that relates to your past, present or future physical or mental health or condition. Protected health information is stored electronically and is subject to electronic disclosure.

This Privacy Notice describes the practices of the facility listed above and

☐ Any medical staff member and any health care professional who participates in your care;
☐ Any volunteer we allow to help you while you are here; and
☐ All employees of any hospital, clinic, laboratory, or other facility affiliated with **Northwest Specialty Hospital.**

All of these people follow the terms of this Privacy Notice. They may also share protected health information with each other for treatment, payment or health care operations as described in this Privacy Notice.

I. Uses and Disclosures of Protected Health Information

We may use and disclose your protected health information for purposes described below.

A. **Treatment**. We may use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party for treatment purposes. For example, we may disclose your protected health information to a pharmacy to fill a prescription or to a laboratory to order a blood test. We may also disclose protected health information to physicians who may be treating you or consulting with the facility with respect to your care. In some cases, we may also disclose your protected health information to an outside treatment provider for purposes of the treatment activities of the other provider.

B. **Payment**. We may use and disclose your protected health information to receive payment for the care you receive from the facility. This may include certain communications to your health insurance company to get approval for the procedure that we have scheduled. For example, we may need to disclose information to your health insurance company to get prior approval for the surgery. We may also disclose protected health information to your health insurance company to determine whether you are eligible for benefits or whether a particular service is covered under your health plan. In order to get payment for the services we provide to you, we may also need to disclose your protected health information to your health insurance company to demonstrate the medical necessity of the services or, as required by your insurance company, for utilization review. We may also disclose patient information to another provider involved in your care for the other provider's payment activities. This may include disclosure of demographic information to anesthesia care providers for payment of their services.

C. Operations. We may use or disclose your protected health information, as necessary, for health care operations to facilitate the function of this facility and to provide quality care to all patients. Health care operations include such activities as: quality assessment and improvement activities, employee review activities, training programs including those in which students, trainees, or practitioners in health care learn under supervision, accreditation, certification, licensing or credentialing activities, review and auditing, including compliance reviews, medical reviews, legal services and maintaining compliance programs, and business management and general administrative activities. In certain situations, we may also disclose protected health information to another provider or health plan for their health care operations.

II. Other Uses and Disclosures

We may use or disclose your protected health information without your permission or authorization for a number of reasons including the following:

A. When Legally Required. We will use and disclose your protected health information when we are required to do so by any federal, state or local law.

B. When There Are Risks to Public Health. We may use and disclose your protected health information for public health activities, including:

- To prevent, control, or report disease, injury or disability as permitted by law.
- To report vital events such as birth or death as permitted or required by law.
- To conduct public health surveillance, investigations and interventions as permitted or required by law.
- To collect or report adverse events and product defects, track FDA regulated products, enable product recalls, repairs or replacements to the FDA and to conduct post marketing surveillance.
- To notify a person who has been exposed to a communicable disease or who may be at risk of contracting or spreading a disease as authorized by law.

C. To Report Suspended Abuse, Neglect Or Domestic Violence. We may notify government authorities if we believe that an individual is the victim of abuse, neglect or domestic violence. We will make this disclosure only when specifically required or authorized by law or when the individual agrees to the disclosure.

D. To Conduct Health Oversight Activities. We may use and disclose your protected health information for health oversight activities including audits; civil, administrative, or criminal investigations, proceedings, or actions; inspections; licensure or disciplinary actions; or other activities necessary for appropriate oversight as authorized by law. We will not disclose your health information under this authority if you are the subject of an investigation and your health information is not directly related to your receipt of health care or public benefits.

E. In Connection With Judicial And Administrative Proceedings. We may disclose your protected health information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by such order. In certain circumstances, we may disclose your protected health information in response to a subpoena if we receive satisfactory assurances that you have been notified of the request or that an effort was made to secure a protective order.

F. For Law Enforcement Purposes. We may disclose your protected health information to a law enforcement official for law enforcement purposes including:

- As required by law for reporting of certain types of wounds or other physical injuries.
- Pursuant to court order, court-ordered warrant, subpoena, summons or similar process.
- For the purpose of identifying or locating a suspect, fugitive, material witness or missing person.
- Under certain limited circumstances, when you are the victim of a crime.
- To a law enforcement official if the facility has a suspicion that your health condition was the result of criminal conduct.
- In an emergency to report a crime.

G. To Coroners, Funeral Directors, and for Organ Donation. We may disclose protected health information to a coroner or medical examiner for identification purposes, to determine cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

H. For Research Purposes. We may use or disclose your protected health information for research when the use or disclosure for research has been approved by an institutional review board that has reviewed the research proposal and research protocols to address the privacy of your protected health information.

I. In the Event of a Serious Threat to Health or Safety. We may, consistent with applicable law and ethical standards of conduct, use or disclose your protected health information if we believe, in good faith, that such use or disclosure is necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health and safety of the public.

J. For Specified Government Functions. In certain circumstances, federal regulations authorize the facility to use or disclose your protected health information to facilitate specified government functions relating to military and veterans activities, national security and intelligence activities, protective services for the President and others, medical suitability determinations, correctional institutions, and law enforcement custodial situations.

K. For Worker's Compensation. The facility may release your health information to comply with worker's compensation laws or similar programs.

L. To Business Associates. We may disclose your protected health information to third parties known as "Business Associates" that perform various activities (e.g. legal services, delivery of goods) for us and that agree to protect the privacy of your protected health information.

III. Uses and Disclosures Permitted without Authorization but with Opportunity to Object

Unless you object, we may disclose to your family members or others involved in your care or payment for your care, information relevant to their involvement in your care or payment for your care or information necessary to inform them of your location and condition. We may also disclose your protected health information to disaster relief agencies so they may assist in notifying those involved in your care of your location and general condition.

Unless you object, we may disclose certain information about you including your name, your general health status and where you are in our facility in a facility directory. We may disclose this information to people who ask for you by name, and we may disclose this information plus your religions affiliation to clergy.

You may object to these disclosures. If you do not object to these disclosures or we can infer from the circumstances that you do not object or we determine, in the exercise of our professional judgment, that it is in your best interests for us to make disclosure of information that is directly relevant to the person's involvement with your care, we may disclose your protected health information as described.

IV. Uses and Disclosures which you Authorize

Other than as stated above, we will not disclose your health information other than with a written authorization from you or your personal representative. You may revoke your authorization in writing at any time except to the extent that we have taken action in reliance upon the authorization. Subject to compliance with limited exceptions, we will not use or disclose psychotherapy notes, use or disclose your health information for marketing purposes or sell your health information, unless you have signed an authorization. You may revoke an authorization by notifying us in writing, except to the extent we have taken action in reliance on the authorization.

V. Your Rights

You have the following rights regarding your health information:

A. <u>The right to inspect and copy your protected health information.</u> You may inspect and obtain a copy of your protected health information that is contained in a designated record set for as long as we maintain the protected health information. A "designated record set" contains medical and billing records and any other records that your surgeon and the facility uses for making decisions about you. We may deny your request to inspect or copy your protected health information in limited circumstances.

To inspect and copy your medical information, you must submit a written request to the Privacy Officer whose contact information is listed on the last page of this Privacy Notice. If you request a copy of your information, we may charge you a fee for the costs of copying, mailing or other costs incurred by us in complying with your request. If your information is stored electronically and you request an electronic copy, we will provide it to you in a readable electronic form and format if it is readily producible in the format you request.

Please contact our Privacy Officer if you have questions about access to your medical record.

B. <u>The right to request a restriction on uses and disclosures of your protected health information.</u> You may ask us not to use or disclose your protected health information for the purposes of treatment, payment or health care operations. You may also request that we not disclose your health information to family members or friends who may be involved in your care or for notification purposes as described in this Privacy Notice. Your request must state the specific restriction requested and to whom you want the restriction to apply.

The facility is not required to agree to a restriction that you may request except for requests to limit disclosures to your health plan for purposes of payment or health care operations when you have paid for the item or service covered by the request out-of-pocket and in full and when the uses or disclosures are not required by law. We will notify you if we deny your request to a restriction. If the facility does agree to the requested restriction, we may not use or disclose your protected health information in

violation of that restriction unless it is needed to provide emergency treatment. You may request a restriction by contacting the Privacy Officer.

C. **The right to request to receive confidential communications from us by alternative means or at an alternative location.** You have the right to request that we communicate with you in certain ways. We will accommodate reasonable requests. We may condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not require you to provide an explanation for your request. Requests must be made in writing to our Privacy Officer.

D. **The right to request amendments to your protected health information.** You may request an amendment of your protected health information if you believe such information is inaccurate or incomplete. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Requests for amendment must be in writing and must be directed to our Privacy Officer. In this written request, you must also provide a reason to support the requested amendments.

E. **The right to receive an accounting.** You have the right to request an accounting of certain disclosures of your protected health information made by the facility. This right applies to disclosures for purposes other than treatment, payment or health care operations as described in this Privacy Notice. We are also not required to account for disclosures that you requested, disclosures that you agreed to by signing an authorization form, disclosures for a facility directory, to friends or family members involved in your care, or certain other disclosures we are permitted to make without your authorization. The request for an accounting must be made in writing to our Privacy Officer. The request should specify the time period sought for the accounting. We are only required to maintain an accounting of disclosures of your protected health information for six years from the date of disclosure. We will provide the first accounting you request during any 12-month period without charge. Subsequent accounting requests may be subject to a reasonable cost-based fee.

F. **The right to obtain a paper copy of this notice.** Upon request, we will provide a separate paper copy of this notice even if you have already received a copy of the notice or have agreed to accept this notice electronically. You may also obtain a copy of the current version of our Privacy Notice at our website, **www.northwestspecialtyhospital.com.**

VI. Our Duties

We are required by law to maintain the privacy of your health information and to provide you with this Privacy Notice of our duties and privacy practices. If we discover a breach by us or our Business Associates involving your unsecured protected health information, we are required to notify you of the breach by letter or other method permitted by law. We are required to abide by terms of this Privacy Notice as may be amended from time to time. We reserve the right to change the terms of this Privacy Notice and to make the new provisions effective for all future protected health information that we maintain. If we change our Privacy Notice, we will provide a copy of the revised Privacy Notice to you or your personal representative upon request.

VII. Complaints

You have the right to express complaints to the facility and to the Secretary of the U.S. Department of Health and Human Services by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775,or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/ if you believe that your privacy rights have been violated. You may complain to the facility by contacting the facility's Privacy Officer verbally or in writing, using the contact information below. We encourage you to express

any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

VIII. Contact Person

The facility's contact person for all issues regarding patient privacy and your rights under the federal privacy standards is the Privacy Officer. Information regarding matters covered by this Notice can be requested by contacting the Privacy Officer. If you feel that your privacy rights have been violated by this facility you may submit a complaint directly to the facility's Privacy Officer OR to the Secretary of the U.S. Department of Health and Human Services. The contact information is as follows:

Northwest Specialty Hospital
1593 E. Polston Ave.
Post Falls, ID 83854
ATTN: Privacy Officer

The facility's Privacy Officer can also be contacted by telephone at 208-262-2619.

IX. Effective Date

This Notice is effective January 16th, 2017.