Consent for Outpatient Clinics

I understand that this OU Health Consent for Outpatient Care applies to my or my minor child's visits (referred to together as "I" and "my"), to all OU Health outpatient locations.

1. General Consent for Treatment
I voluntarily consent to receive care which may be performed during an outpatient episode of care, including, but not limited to, physical examinations, laboratory procedures, x-ray examination, diagnostic procedures, and medical treatment by an OU Health provider and/or staff member for myself or minor child.

A. Continuing Medical Education
I understand that OU Health allows students and residents of various health care specialties to observe and/or participate in providing care, including physical examinations, diagnostic procedures, and x-ray examinations. I understand instructors and/or OU Health staff will supervise these students as part of their educational program. These examinations and this treatment may be observed directly, or by the use of one-way mirror or closed-circuit television, for training and supervision purposes. I will be informed if observation is involved. I understand that faculty members, trainees, and students will also have access to counseling and psychiatric records for training purposes, and such access is only permitted under supervision. I consent to the observation and participation of healthcare students in the provision of my care. I understand that I have a right to withhold or withdraw my consent of the use of students in the course of my care at any time, without affecting my right to future treatment and without risking the loss or withdrawal of any program benefit to which I would otherwise be entitled.

2. Consent to Treatment Using Telemedicine
I voluntarily consent to treatment involving the use of electronic communications ("Telemedicine") to enable healthcare providers at different locations to share my individual patient medical information for diagnosis, therapy, follow-up, and/or education purposes. I consent to forwarding my information to a third party as
needed to receive Telemedicine services, and I understand that existing confidentiality protections apply. I acknowledge that while Telemedicine can be used to provide improved access to care, as with any medical procedure, there are potential risks and results cannot be guaranteed or assured. These risks include, but are not limited to technical problems with the information transmission or equipment failures that could result in lost information or delays in treatment. I understand that I have a right to withhold or withdraw my consent to the use of Telemedicine in the course of my care at any time, without affecting my right to future treatment and without risking the loss or withdrawal of any program benefit to which I would otherwise be entitled.

3. Consent to Medication Not Yet FDA Approved and/or Medication Prepared/Repackaged by Outsourcing or Compounding Pharmacy
As part of the services provided, I may be treated with a medication that has not received FDA approval. I may also receive a medication that has been prepared or repackaged by an outsourcing facility or compounding pharmacy. Certain medications, for which there are no alternatives or which my physician recommends, may be necessary for potentially life-saving treatment.

4. Consent to Photographs, Videotapes and Audio Recordings
I understand that my picture may be taken by Patient Registration staff for the purpose of patient identification. This is to help combat identity theft and fraud, and may take the place of my need to

formally identify myself on admission. I consent to photographs, videotapes, digital or audio recordings, and/or images of me being recorded for security purposes and/or OU Health's quality improvement and/
or risk management activities. I understand that OU Health retains the ownership rights to the images and/or recordings. I will be allowed to request access to, or copies of, the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used outside of OU Health without a specific written authorization from me or my legal representative, unless otherwise required by law.

5. Consent to Continuity of Care
The federal confidentiality law and regulations permits patient information be disclosed to Health Information Organizations and other health information exchange (HIE) systems. I understand that my health information may be shared for the purposes of my care and treatment with other hospitals and treatment facilities using electronic exchange systems.

6. Financial Agreement and Payment Responsibility
I agree to be financially responsible for any services provided to me or the patient for which I am responsible, including any deductibles, copayments and charges for services not paid for or provided by health insurance benefits. The rates are set by OU Health's price list ("Chargemaster") as of the date of treatment. I agree to pay for services as they are provided and/or pay the balance due promptly upon receipt of a statement. An estimate of the anticipated charges for services to be provided to me is available upon request from OU Health. Estimates may vary significantly from the final charges based on a variety of factors, including, but not limited to, the course of treatment, intensity of care, physician practices, and the necessity of providing additional goods and services. Most, or all of the physicians performing services at OU Health are independent and are not OU Health agents or employees. **Professional services rendered by independent contractors are not part of the OU Health bill. These services will be billed to me separately.** If I am uninsured and not covered by a governmental program, I may be eligible to have my account discounted or forgiven under OU Health's Financial Assistance program. I understand that I may request information about this program from OU Health. I also understand that, as a courtesy to me, OU Health may bill an insurance company offering coverage, but may not be obligated to do so. Upon written request, OU Health will provide the information necessary for me to file the insurance claim, except as prohibited by law.

7. Third Party Collection
I acknowledge that OU Health may utilize the services of a third-party Business Associate or affiliated entity as an extended business office ("EBO Servicer") for medical account billing and servicing. During the time that the medical account is being serviced by the EBO Servicer, the account is not considered delinquent, past due or in default, and will not be reported to a credit bureau or subject to collection legal proceedings. Once the medical account is determined to be delinquent, it may be subject to late fees, interest as stated, referral to a collection agency as a delinquent account, credit bureau reporting and enforcement by legal proceedings. I also understand that if OU Health initiates collection efforts to recover amounts owed by me or my Guarantor, then, in addition to amounts incurred for the services rendered, I, or my Guarantor will pay, to the extent permitted by law: (a) any and all costs incurred by the Provider in pursuing collections, including, but not limited to, reasonable attorneys' fees, and (b) any court costs or other costs of litigation incurred by the Provider.

8. Authorization to Release Information and Assignment of Insurance Benefits
I understand that OU Health will release information to my insurance company or responsible party necessary to secure payment for services rendered, and I assign payment of insurance benefits to OU Health and other providers for such services.

9. Medicare Patient Certification and Assignment of Benefit (for Medicare patients only)
I certify that any information I provide in applying for payment under Title XVIII ("Medicare") or Title XIX ("Medicaid") of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to OU Health or OU Health-based physician(s) by the Medicare or Medicaid program.

10. Outpatient Medicare Patients
Medicare does not provide coverage for "self-administered drugs" or drugs that I normally take on my own, with only a few limited exceptions. If I receive self-administered drugs that aren't covered by Medicare Part B, I may be billed for the drug. However, if I am enrolled in a Medicare Part D Drug Plan, these drugs may be covered with Medicare Part D Drug Plan enrollment materials. If I pay for these self-administered drugs, I can submit a claim to my Medicare Part D Drug Plan for a possible refund.

11. Prescriptions
I consent to OU Health accessing prescription databases to review my prior and ongoing prescription history. I may revoke this consent by notifying OU Health in writing. If I do not provide consent or if I revoke this consent, I may be terminated as an OU Health patient.

12. Consent to Authorize Use of Email and/or Text for Patient Billing and Financial Obligations
By my consent below, I authorize the use of any email address or cellular telephone number I provide for receiving information related to my financial obligations, including, but not limited to: payment reminders, delinquent notifications, instructions and links to OU Health patient billing information. I understand and acknowledge that my patient account number may appear in the email or text. I consent to receiving discharge instructions and other healthcare communications at the email or text address I have provided, or OU Health or the EBO Servicer have obtained, at any text number forwarded or transferred from that number.

Acknowledge (check one or both):

☐ I consent to use of email for Patient billing and financial obligation purposes.

☐ I consent to use of text for Patient billing and financial obligation purposes.

13. Appointment/Refill Reminders
OU Health wants to ensure that we effectively communicate with our patients. I have been advised that OU Health clinics may provide appointment and refill reminders via mail, secure email or patient portal, text, and automated or live telephone messages. I understand that text messages may not be encrypted, so it is possible for them to be viewed by unauthorized individuals.

14. Communications Regarding Education, Feedback and Events
OU Health may send me health-related educational materials; patient experience surveys; requests for completion of my medical, social, and family history information to facilitate care; notices about special events for patients and family members such as camps and classes; and recognition of special milestones. I understand that these types of communications may be made by phone, secure email, mail, patient portal, and text messaging. Text messages may not be encrypted, so it is possible for them to be viewed
by unauthorized individuals.

15. Leaving Messages
I understand there are times when OU Health may not be able to reach me. OU Health may leave a message that includes information about my health.

☐**16. Acknowledgement of Receipt of Notice of Privacy Practices.**
I acknowledge that I have received OU Health's Notice of Privacy Practices, which describes the ways in which OU Health may use and disclose my healthcare information for the purposes of my treatment,

payment for my treatment, and OU Health's healthcare operations. OU Health will also use and share my health information as required/permitted by law.

I understand that I may contact OU Health's Privacy
Officer designated on the notice if I have a question or complaint.

☐ **17. Acknowledgement of Receipt of Notice of Patient Rights and Responsibilities**
I have been furnished with a Statement of Patient Rights and Responsibilities ensuring that I am treated with respect and dignity and without discrimination or distinction based on age, gender, disability, race, color, ancestry, citizenship, religion, pregnancy, sexual orientation, gender identity or expression, national origin, medical condition, marital status, veteran status, payment source or ability, or any other basis prohibited by federal, state, or local law.

☐ **18. Acknowledgement**
I have been given the opportunity to read and ask questions about the information contained in this form, specifically including but not limited to the financial obligation's provisions and assignment of benefit provisions, and I acknowledge that I either have no questions or that my questions have been answered to my satisfaction. I understand that these items are effective indefinitely unless revoked.

This consent applies to services you receive from all healthcare providers listed above, occurring or commencing within one year from the date of this agreement.

Patient/Patient Representative Signature:

_____

Date:

If you are not the Patient, please identify your Relationship to the Patient. (Circle or mark relationship(s) from list below):

☐ Spouse ☐ Parent ☐ Legal Guardian ☐ Sibling
☐ Healthcare Power of Attorney ☐ Guarantor ☐ Other (Please Specify)

Please fill out "Other" below:

_____

Witness Signature and Title:

(Required for Patients unable to sign without a representative or Patients who refuse to sign)

Treatment Advocate Authorization

(This form grants authority to a designated adult to provide and arrange for outpatient behavioral health care at the OU Health Child Study Center for a minor in the event the minor cannot be accompanied by either parent or legal guardian.)

At this time, I do not wish to name a treatment advocate ☐

PLEASE PRINT

I, _____, the parent or legal guardian of _____

Date of Birth_____ do hereby consent and authorize the following individuals to take part in the child's visit including but not limited to:

- Transportation to and from visit
- Picking up medications for child
- Attending medical/behavioral health assessments/treatment or discharge planning appointments
- Help in any medical/behavioral health decisions necessary to ensure proper treatment.

I do not want my treatment advocate to: _____
Treatment advocates will act in the best interest of the child and comply with confidentiality.

Designated Adult _____Relationship to child_____

Designated Adult _____Relationship to child_____

Designated Adult _____Relationship to child_____

Designated Adult _____Relationship to child_____

This authorization is effective on this _____day of _____, 20_____

This consent does not expire, but is revocable by legal guardian/parent at any time.

_____	_____	_____
Signature of Parent or Legal Guardian	Date	Print Name
_____	_____	_____
Signature of Witness	Date	Print Name

OU Health Child Study Center
1100 NE 13th Street Oklahoma City, OK 73117
(P) 405-271-5700 (F) 405-271-8835

OU Health
Clinical Operations Outpatient Behavioral Health

GRIEVANCE PROCESS

Who may file a grievance? Any consumer of the services of OU Health Outpatient Behavioral Health Program or any person interested in the wellbeing of the consumer (e.g., relative, treatment advocate) may file a grievance. The grievance processes for behavioral health services are aligned closely with the overall OU Health customer grievance policies, procedures, and Patient Bill of Rights.

What complaints are considered? The complaint may be about any rule, policy, action, decision or conditions permitted by OU Health, any employee or any other person paid by OU Health Clinical Operations Outpatient Behavioral Health to care for a member.

When a grievance may be filed? It is important to file grievances as soon as possible.
How to file a grievance? You can submit your grievance in writing or directly to the advocates listed below, who will enter the information into our feedback system. Your local advocate is available to assist you, Monday-Friday 8am-5pm. Within 14 days of receiving your grievance, an attempt will be made, with your participation, to resolve the problem. You will receive a response in writing.

Persons Responsible for Grievance Reporting and Resolution:

Local Advocate	Dr. Michael Brand	405-271-8001, ext 47666
Grievance Coordinators	Risk Services	405-271-1800
Decision Maker	Dr. Jim Scott	405-271-8001, ext 47653

You have the right to file a grievance, to receive a written response to your complaint and to appeal if you are not satisfied with the response. You have the right to contact any of the persons listed in these tables at any time in the process. If any person attempts to deny you these rights or penalize you for filing a grievance, contact any of the following:

Department	Name/Number	Toll-Free Number	Address
OU Health Patient Safety	Risk Services	405-271-1800	1200 Children's Ave, STE 1100, OKC, OK 73104
ODMHSAS Consumer Advocate	405-573-6605	866-699-6605	PO Box 151 Norman, OK 73070
Office of Inspector General	405-248-9037	866-699-6605	2000 N. Classen Blvd # E600, OKC, OK 73106

I acknowledge that this Grievance Process has been explained to me by _____
and that I have received a copy of the process along with the agency names & addresses for additional grievance assistance.

_____	_____	_____
Member Signature	Date	Time
_____	_____	_____
Parent/Guardian Signature	Date	Time

Member Name:_____ Date of Birth:_____

OU Health

Outpatient Behavioral Health

Acknowledgement of Patient Rights and Responsibilities, and Bill of Rights

I have received a copy of the OU Health Patient Rights and Responsibilities, and a copy of the Synopsis of the Oklahoma Department of Mental Health and Substance Abuse Services Bill of Rights. I have had an opportunity to ask clarifying questions about these documents.

_____ _____

Date/Time Signature of Person Completing Form

_____ _____

Member Name Date of Birth

OU Health Child Study Center

1100 N.E. 13th Street
Oklahoma City, OK 73117
(405) 271-5700-Phone
(405) 271-8835- Fax

Patients must bring a photo ID and insurance card to every visit

Contact Information

The Child Study Center is open Monday through Friday **8:00am until 5:00pm** with our phone lines being closed for lunch from 12:00pm to 1:00pm each day. Clinical activity may occur outside of these hours, so please check with your provider.

Phone-	405-271-5700
Direct-	405-271-8001 & dial extension
Fax-	405-271-8835
Email-	childstudycenter@ouhealth.com
Patient Portal-	MyChart

Emergency & After-Hours Care Information

If you have a life-threatening emergency or behavioral health crisis involving suicidal thoughts or behavior, please dial 911, visit your nearest emergency room, or **text HELP to 988.**

If you have urgent concerns regarding prescribed medication after 5:00pm, please contact the campus operator at **405-271-4700** and ask for the on-call physician for the Child Study Center.

Scheduling Appointments

New appointments can be made by referral. We accept referrals from primary care providers, DHS, or self-referrals from families. Please note we have extended wait times for some of our clinical programs.

To schedule a *follow-up medical appointment*, please contact our office at 405-271-5700 or schedule through MyChart.

Non-Medical therapy appointments can be scheduled directly with your provider.

Secure Patient Portal-MyChart

OU Health now offers a new and improved patient portal through MyChart. This new portal allows you to securely access you or your child's online medical record. You can send messages to the provider, view test results, renew prescriptions, schedule follow-up appointments, and make payments to your account.

To sign up, please visit mychart.ouhealth.com

Phone Calls

Our goal is to return patient phone calls within one business day. At times, the provider and staff may be assisting other patients. Please leave a message with your name, phone number, child's name, their date of birth, provider that they typically see, and reason for calling and we will return your call as soon as possible. Calls received after 3:00pm may be returned the next business day.

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Arrival Time, Cancellations, and No-Shows

All patients should arrive *15 minutes prior to the appointment time*. If you are a new patient, please bring any completed paperwork. Patients who arrive late may be asked to reschedule.

We kindly ask if you must change an appointment for your child, please give us at least *24 hours' notice*. This courtesy makes it possible to give your reserved time to another child who needs it. If you fail to contact us within this 24-hour time period, it will be considered a no-show.

No-Show Policy

It is the policy of this practice to monitor and manage appointment no-shows and late cancellations. *Established patients* are allowed **three (3)** no-shows in a 12-month rolling period before the practice can request the patient to be terminated from care.

In the event of **two (2)** documented no-showed appointments for a *new patient visit*, the child will be sent to the end of the wait list for the next scheduled visit

Interpretive Services

Child Study Center offers the Language Access Network (MARTTI) to our patients. There are over 100 languages offered including ALS services. Please notify the front desk prior to the appointment if these services are needed.

Wheel Chairs/Restrooms

We are a handicap accessible facility and as such we have wheel chairs and handicap accessible restrooms when needed. Please let your scheduler or front desk know if these are needed.

Alternative Caregivers (grandparent, brother, aunt, step-parent, etc)

If someone other than a bio-parent or legal guardian will be accompanying the child to an appointment, please make sure to notify the front desk or scheduler. We will need a signed *Alternative Caregiver Consent Form* in the chart prior to the visit. This form is required for them to participate in the visit and must be completed by the parent or legal guardian.

Minors in the Lobby

No child 7 years and younger should be left unattended in our lobby. It will be at the discretion of the provider and caregiver if those who are 8 years and older can be left unattended for short periods of time. Please notify the front desk and your provider when this occurs.

Medication Refills

For safety reasons, the child must have been seen within the last 6 months and/or have an appointment scheduled with us in our system to continue receiving medication refills. If that appointment is not attended, no further refills will be approved and given until the child is seen again in clinic.

Please **DO NOT** wait until your child is out of medication before calling your pharmacy or our office. Allow at least 3 business days for completing your refill requests.

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Parking

Child Study Center has parking (including handicap spaces) available directly in front of our building. Upon arriving for your visit, you must come in and retrieve a parking pass from the front desk. **Please place this on your dashboard**. Skipping this step could result in a parking ticket from a third-party parking vendor on campus.

Payment Policy

Child Study Center will file your insurance claim for you. Your payment portion is due at time of visit. If you do not have insurance coverage, you may contact your county DHS office, the SoonerCare Helpline at (800) 987-7767 or online at Mysoonercare.org to explore other resources. In addition, payment plans may be arranged by calling OU Health Patient Accounts at 405-271-1500.

Conduct Expectation

Child Study Center expects all visitors, patients, providers, and staff to conduct themselves in a professional, respectful manner at all times. Concerns with providers and staff can be reported to management at any time in any clinic location. Disruptive patients and visitors may be asked to leave and/or be dismissed from the practice.

Tobacco/Firearms/Seclusion & Restraint

OU Health and the campus of OUHSC is a tobacco-free environment. This includes vaping.

OU health and the OUHSC police department enforce all state and federal laws concerning illegal drugs. Any persons caught in possession of, using, or selling will be detained.

No firearms or weapons are allowed on the OUHSC campus or in our clinic.

OUH staff do not practice seclusion, restraint, physical holds, or emergency interventions on their clients.

We are here to assure your safety and well-being while in our facility. If you have any questions or concerns about the above outlined procedures, please feel free to contact our office at 405-271-5700.

_____

Patient Name Date of Birth

_____

Caregiver/Legal Guardian Date

I have read and understand the policies as outlined above. I understand by signing this form I am consenting to these rules and understand my responsibility as a patient/caregiver.

OU Physicians

Outpatient Behavioral Health

Synopsis of the Bill of Rights
Consumer/Guardian Notification

Our program provides voluntary outpatient treatment and service. We shall support and protect the fundamental human, civil, and constitutional rights of the individual consumer.

Each consumer has the right to be treated with respect and dignity.

Furthermore:

(1) Each consumer shall retain all rights, benefits, and privileges guaranteed by law except those lost through due process of law.
(2) Each consumer has the right to receive services suited to his or her condition in a safe, sanitary and humane treatment environment regardless of race, religion, gender, ethnicity, age, degree of disability, handicapping condition or sexual orientation.
(3) No consumer shall be neglected or sexually, physically, verbally, or otherwise abused.
(4) Each consumer shall be provided with prompt, competent, and appropriate treatment; and an individualized treatment plan. **A consumer shall participate in his or her treatment programs and may consent or refuse to consent to the proposed treatment**. The right to consent or refuse to consent may be abridged for those consumers adjudged incompetent by a court of competent jurisdiction and in emergency situations as defined by law. Additionally, each consumer shall have the right to the following:

- Allow other individuals of the consumer's choice participate in the consumer's treatment and with the consumer's consent;
- To be free from unnecessary, inappropriate, or excessive treatment;
- To participate in consumer's own treatment planning;
- To receive treatment for co-occurring disorders if present;
- To not be subject to unnecessary, inappropriate, or unsafe termination from treatment; and
- To not be discharged for displaying symptoms of the consumer's disorder.

(5) Every consumer's record shall be treated in a confidential manner.
(6) No consumer shall be required to participate in any research project or medical experiment without his or her informed consent as defined by law. Refusal to participate shall not affect the services available to the consumer.
(7) A consumer shall have the right to assert grievances with respect to an alleged infringement on his or her rights.
(8) Each consumer has the right to request the opinion of an outside medical or psychiatric consultant at his or her own expense or a right to an internal consultation upon request at no expense.
(9) No consumer shall be retaliated against or subjected to any adverse change of conditions or treatment because the consumer asserted his or her rights.

You may contact the ODMHSAS Consumer Advocate or Office of the Inspector General with any concerns:

Office of Consumer Advocacy-Oklahoma Department of Mental Health & Substance Abuse Services: (866) 699-6605.

Office of the Inspector General-Oklahoma Department of Mental Health & Substance Abuse Service: (800) 522-9054.

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(405) 271-5700-Phone
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Patient Rights and Responsibilities

At OU Health, patients and their families will be treated with respect, transparency, and will be encouraged to actively participate in their child's care. Here of some of your rights and responsibilities.

As a patient/caregiver, I have rights:

- The right to impartial access to treatment.
- The right to considerate and respectful care.
- The right to have confidentiality of your personal information and medical records.
- The right to participate in the decision-making about your child's treatment, care, and discharge.
- The right to reasonable safety and security while in our environment of care.
- The right to receive services in a culturally sensitive way.

As a patient/caregiver, I have responsibilities:

- The responsibility to provide accurate and complete information.
- The responsibility to report unexpected changes in child's his/her condition.
- The responsibility to follow ALL clinic rules and regulations.
- The responsibility to treat staff, providers, and other patients & visitors with courtesy and respect.

*Each patient will be given a copy of the full Patient Bill of Rights within their new patient packet.

Notice of Privacy Practices

This NOTICE describes your rights regarding you medical information and informs you of how it may be used and disclosed. It applies to the health information that is protected by the Health Insurance Portability and Accountability Act (HIPAA). Used to make decisions about your care, and generated or maintained by OU Health (OUH). Please review it carefully.

If you have any questions about this notice, please contact Amber Simpson, the Facility Privacy Official by dialing (405) 271-5920.

Each time you visit a hospital, physician, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, a plan for future care or treatment, and billing-related information. This notice applies to all of the records of your care generated by the facility, whether made by facility personnel, agents of the facility, or your personal doctor. Your personal doctor may have different policies or notices regarding the doctor's use and disclosure of your health information created in the doctor's office or clinic.

Our Responsibilities

We are required by law to maintain the privacy of your health information, provide you a description of our privacy practices, and to notify you following a breach of unsecured protected health information. We will abide by the terms of this notice.

Uses and Disclosures

How we may use and disclose Health Information about you.

The following categories describe examples of the way we use and disclose health information:

For Treatment: We may use health information about you to provide you treatment or services. We may disclose health information about you to doctors, nurses, technicians, medical students, or other facility personnel who are involved in taking care of you at the facility. For example: a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. Different departments of the facility also may share health information about you in order to coordinate the different things you may need, such as prescriptions, lab work, meals, and x-rays.
We may also provide your physician or a subsequent healthcare provider with copies of various reports that should assist him or her in treating you once you're discharged from this facility.
For Payment: We may use and disclose health information about your treatment and services to bill and collect payment from you, your insurance company or a third party payer. For example, we may need to give your insurance company information about your surgery so they will pay us or reimburse you for the treatment. We may also tell your health plan about treatment you are going to receive to determine whether your plan will cover it. We may release your information to a collection agency if your account is not paid.
For Health Care Operations: Members of the medical staff and/or quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. The results will then be used to continually improve the quality of care for all patients we serve. For example, we may combine health information about many patients to evaluate the need for new services or treatment. We may disclose information to doctors, nurses, and other students for educational purposes. And we may combine health information we have with that of other facilities to see where we can make improvements. We may remove information that identifies you from this set of health information to protect your privacy.
Fundraising: We may contact you to raise funds for the facility; however, you have the right to elect not to receive such communications.

We may also use and disclose health information:

- To remind you that you have an appointment for medical care;
- To assess your satisfaction with our services;
- To tell you about possible treatment alternatives;
- To tell you about health–related benefits or services;
- For population based activities relating to improving health or reducing health care costs;
- For conducting training programs or reviewing competence of health care professionals; and
- To a Medicaid eligibility database and the Children's Health Insurance Program eligibility database, as applicable.

When disclosing information, primarily appointment reminders and billing/collections efforts, we may leave messages on your answering machine/voice mail.
Business Associates: There are some services provided in our organization through contracts with business associates. Examples include physician services in the emergency department and radiology, certain laboratory tests, and a copy service we use when making copies of your health record. When these services are contracted, we may disclose your health information to our business associates so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, business associates are required by federal law to appropriately safeguard your information.
Directory: We may include certain limited information about you in the facility directory while you are a patient at the facility. The information may include your name, location in the facility, your general condition (e.g., good, fair) and your religious affiliation. This information may be provided to members of the clergy and, except for religious affiliation, to other people who ask for you by name. If you would like to opt out of being in the facility directory please request the Opt Out Form from the admission staff or Facility Privacy Official.
Individuals Involved in Your Care or Payment for Your Care and/or Notification Purposes: We may release health information about you to a friend or family member who is involved in your medical care or who helps pay for your care or to notify, or assist in the notification of (including identifying or locating), a family member, your personal representative, or another person responsible for your care of your location and general condition. In addition, we may disclose health information about you to an entity assisting in a disaster relief effort in order to assist with the provision of this notice.
Research: The use of health information is important to develop new knowledge and improve medical care. We may use or disclose health information for research studies but only when they meet all federal and state requirements to protect your privacy (such as using only de-identified data whenever possible). You may also be contacted to participate in a research study.
Future Communications: We may communicate to you via newsletters, mail outs or other means regarding treatment options, health related information, disease-management programs, wellness programs, research projects, or other community based initiatives or activities our facility is participating in.
Organized Health Care Arrangement: This facility and its medical staff members have organized and are presenting you this document as a joint notice. Information will be shared as necessary to carry out treatment, payment and health care operations. Physicians and caregivers may have access to protected health information in their offices to assist in reviewing past treatment as it may affect treatment at the time.
Affiliated Covered Entity: Protected health information will be made available to facility personnel at local affiliated facilities as necessary to carry out treatment, payment and health care operations. Caregivers at other facilities may have access to protected health information at their locations to assist in reviewing past treatment information as it may affect treatment at this time. Please contact the Facility Privacy Official for further information on the specific sites included in this affiliated covered entity.
Health Information Exchange/Regional Health Information Organization: Federal and state laws may permit us to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share your health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of your health records; decreasing the time needed to access your information; aggregating and comparing your information for quality improvement purposes; and such other purposes as may be permitted by law.

As required by law. We may disclose information when required to do so by law.

As permitted by law, we may also use and disclose health information for the following types of entities, including but not limited to:

- Food and Drug Administration
- Public Health or Legal Authorities charged with preventing or controlling disease, injury or disability
- Correctional Institutions
- Workers Compensation Agents
- Organ and Tissue Donation Organizations
- Military Command Authorities
- Health Oversight Agencies
- Funeral Directors and Coroners
- National Security and Intelligence Agencies
- Protective Services for the President and Others
- A person or persons able to prevent or lessen a serious threat to health or safety

Law Enforcement: We may disclose health information to a law enforcement official for purposes such as providing limited information to locate a missing person or report a crime.
For Judicial or Administrative Proceedings: We may disclose protected health information as permitted by law in connection with judicial or administrative proceedings, such as in response to a court order, search warrant or subpoena.
Authorization Required: We must obtain your written authorization in order to use or disclose psychotherapy notes, use or disclose your protected health information for marketing purposes, or to sell your protected health information.
State-Specific Requirements: Many states have requirements for reporting including population-based activities relating to improving health or reducing health care costs. Some states have separate privacy laws that may apply additional legal requirements. If the state privacy laws are more stringent than federal privacy laws, the state law preempts the federal law.

Your Health Information Rights

Although your health record is the physical property of the healthcare practitioner or facility that compiled it, you have the right to:
• **Inspect and Copy:** You have the right to inspect and obtain a copy of the health information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to health information, you may request that the denial be reviewed. Another licensed health care professional chosen by the facility will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.
• **Amend:** If you feel that health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the facility. Any request for an amendment must be sent in writing to the Facility Privacy Official.
We may deny your request for an amendment and if this occurs, you will be notified of the reason for the denial.
• **An Accounting of Disclosures:** You have the right to request an accounting of disclosures. This is a list of certain disclosures we make of your health information for purposes other than treatment, payment or health care operations where an authorization was not required.
• **Request Restrictions:** You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had. Any request for a restriction must be sent in writing to the Facility Privacy Official.
• **We are required to agree to your request only if** 1) except as otherwise required by law, the disclosure is to your health plan and the purpose is related to payment or health care operations (and not treatment purposes), and 2) your information pertains solely to health care services for which you have paid in full. For other requests, we are not required to agree. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.
• **Request Confidential Communications:** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you may ask that we contact you at work instead of your home. The facility will grant reasonable requests for confidential communications at alternative locations and/or via alternative means only if the request is submitted in writing and the written request includes a mailing address where the individual will receive bills for services rendered by the facility and related correspondence regarding payment for services. Please realize, we reserve the right to contact you by other means and at other locations if you fail to respond to any communication from us that requires a response. We will notify you in accordance with your original request prior to attempting to contact you by other means or at another location.
• **A Paper Copy of This Notice:** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

OU Health has a website that you may print or view a copy of the notice by clicking on the Notice of Privacy Practices link.

• **Right to be Notified:** You have the right to be notified of breaches that may have compromised the privacy or security of your health information.

To exercise any of your rights, please obtain the required forms from the Privacy Official and submit your request in writing.

CHANGES TO THIS NOTICE

We reserve the right to change this notice and the revised or changed notice will be effective for information we already have about you as well as any information we receive in the future. The current notice will be posted in the facility and on our website and include the effective date. In addition, each time you register at or are admitted to the facility for treatment or health care services as an inpatient or outpatient, we will offer you a copy of the current notice in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the facility by following the process outlined in the facility's Patient Rights documentation. You may also file a complaint with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing.

You will not be retaliated against for filing a complaint.

OTHER USES OF HEALTH INFORMATION

Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written authorization. If you provide us permission to use or disclose health information about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your authorization, and that we are required to retain our records of the care that we provided to you.

FACILITY PRIVACY OFFICIAL: Amber Simpson
Telephone Number: (405) 271-5920

Effective Date: July 1, 2021

OU Health

Patient Rights and Responsibilities

OU Health respects the dignity and pride of each individual we serve. Every patient has the right to have his/her rights respected without regard to age, gender, disability, race, color, ancestry, citizenship, religion, pregnancy, sexual orientation, gender identity or expression, national origin, medical condition, marital status, veteran status, payment source or ability, or any other basis prohibited by federal, state, or local law. Each individual shall be informed of the patient's rights and responsibilities in advance of administering or discontinuing patient care. We adopt and affirm as policy the following rights of patient/clients who receive services from our facilities:

Considerate and Respectful Care: To receive ethical, high-quality, safe and professional care without discrimination. To be free from all forms of abuse and harassment. To be treated with consideration, respect and recognition of their individuality, including the need for privacy in treatment. This includes the right to request the facility provide a person of one's own gender to be present during certain parts of physical examinations, treatments or procedures performed by a health professional of the opposite sex, except in emergencies, and the right not to remain undressed any longer than is required for accomplishing the medical purpose for which the patient was asked to undress.

Information Regarding Health Status and Care: To be informed of his/her health status in terms that the patient can reasonably be expected to understand, and to participate in the development and the implementation of his/her plan of care and treatment. The right to be informed of the names and functions of all physicians and other health care professionals who are providing direct care to the patient. The right to be informed about any continuing health care requirements after his/her discharge from the hospital. The patient shall also have the right to receive assistance from the physician and appropriate hospital staff in arranging for required follow-up care after discharge. To be informed of risks, benefits and side effects of all medications and treatment procedures, particularly those considered innovative or experimental. To be informed of all appropriate alternative treatment procedures. To be informed of the outcomes of care, treatment and services. To appropriate assessment and management of pain. To be informed if the hospital has authorized other health care and/or education institutions to participate in the patient's treatment. The patient shall also have a right to know the identity and function of these institutions, and may refuse to allow their participation in his/her treatment.

Decisionmaking and Notification: To choose a person to be his/her health care representative and/or decisionmaker. The patient may also exercise his/her right to exclude any family members from participating in his/her health care decisions. To have a family member, chosen representative and/or his or her own physician notified promptly of admission to the hospital. To request or refuse treatment. This right must not be construed as a mechanism to demand the provision of treatment or services deemed medically unnecessary or inappropriate. To be included in experimental research only when he or she gives informed, written consent to such participation. The patient may refuse to participate in experimental research, including the investigations of new drugs and medical devices. To formulate advance directives and have hospital staff and practitioners who provide care in the hospital comply with these directives. To leave the health care facility against your physician's advice to the extent permitted by law.

Access to Services: To receive, as soon as possible, the services of a translator and/or interpreter, telecommunications devices, and any other necessary services or devices to facilitate communication between the patient and the hospitals' health care personnel. To bring a service animal into the facility, except where service animals are specifically prohibited pursuant to facility policy (e.g., operating rooms, patient units where a patient is immunosuppressed or in isolation). To pastoral counseling and to take part in religious and/or social activities while in the hospital, unless your doctor thinks these activities are not medically advised. To safe, secure and sanitary accommodation and a nourishing, well balanced and varied diet. To access people outside the facility by means of verbal and written communication. To have accessibility to facility buildings and grounds. OU Medicine recognizes the Americans with Disabilities Act, a wide-ranging piece of legislation intended to make American society more accessible to people with disabilities. The policy is available upon request. To a prompt and reasonable response to questions and requests for service. To request a discharge planning evaluation.

Access to Medical Records: To have his/her medical records, including all computerized medical information, kept confidential and to access information within a reasonable time frame. The patient may decide who may receive copies of the records except as required by law. Upon leaving the health care facility, patients have the right to obtain copies of their medical records.

Ethical Decisions: To participate in ethical decisions that may arise in the course of care including issues of conflict resolution, withholding resuscitative services, foregoing or withdrawal of life sustaining treatment, and participation in investigational studies or clinical trials. If the health care facility or its team decides that the patient's refusal of treatment prevents him/her from receiving appropriate care according to ethical and professional standards, the relationship with the patient may be terminated.

Protective Services: To access protective and advocacy services. To be free from restraints of any form that are not medically necessary or are used as a means of coercion, discipline, convenience, or retaliation by staff. The patient who receives treatment for mental illness or developmental disability, in addition to the rights listed herein, has the rights provided by any applicable state law. To all legal and civil rights as a citizen unless otherwise prescribed by law. To have upon request an impartial review of hazardous treatments or irreversible surgical treatments prior to implementation except in emergency procedures necessary to preserve your life. To an impartial review of alleged violations of patient rights. To expect emergency procedures to be carried out without unnecessary delay. To give consent to a procedure or treatment and to access the information necessary to provide such consent. To not be required to perform work for the facility unless the work is part of the patient's treatment and is done by choice of the patient. To file a complaint with the Department of Health or other quality improvement, accreditation or other certifying bodies if he or she has a concern about patient abuse, neglect, misappropriation of a patient's property in the facility or other unresolved complaint, patient safety or quality concern.

Payment and Administration: To examine and receive an explanation of the patient's health care facility's bill regardless of source of payment, and may receive upon request, information relating to the availability of known financial resources. A patient who is eligible for Medicare has the right to know, upon request and in advance of treatment, whether the health care provider or health care facility accepts the Medicare assignment rate. To receive, upon request, prior to treatment, a reasonable estimate of charges for medical care. To be informed in writing about the facility policies and procedures for initiation, review and resolution of patient complaints, including the address and telephone number of where complaints may be filed.

Additional Patient Rights: Except in emergencies, the patient may be transferred to another facility only with a full explanation of the reason for transfer, provisions for continuing care and acceptance by the receiving institution. To initiate their own contact with the media. To get the opinion of another physician, including specialists, at the request and expense of the patient. To wear appropriate personal clothing and religious or other symbolic items, as long as they do not interfere with diagnostic procedures or treatment. To request a transfer to another room if another patient or a visitor in the room is unreasonably disturbing him/her. To request pet visitation except where animals are specifically prohibited pursuant to the facility's policies (e.g., operating rooms, patient units where a patient is immunosuppressed or in isolation).

Patient's Right to Complain: You have the right to present complaints regarding any area of your hospital stay or care. You can make these complaints, including reporting to regulatory agencies, without fear of retribution or concern that your care will be compromised. We will assist you in resolving any conflicts. We will assist you with filing a complaint with a regulatory agency. To file a complaint, please contact that department's director. If you would like to bypass the hospital's complaint system, you can contact: Oklahoma State Dept. of Health, Protective Health Services, 1000 NE 10th St., Oklahoma City, 405-271-6576 or The Joint Commission at: www.jointcommission.org, using the "Report a Patient Safety Event" link in the "Action Center" on the home page of the website; by fax to 630-792-5636; by mail to Office of Quality and Patient Safety, The Joint Commission, One Renaissance Boulevard, Oakbrook Terrace, IL 60181.

Patient Responsibilities: The care a patient receives depends partially on the patient him/herself. Therefore, in addition to the above rights, a patient has certain responsibilities. These should be presented to the patient in the spirit of mutual trust and respect.

To provide accurate and complete information concerning his/her health status, medical history, hospitalizations, medications and other matters related to his/her health. To report perceived risks in his/her care and unexpected changes in his/her condition to the responsible practitioner. To report comprehension of a contemplated course of action and what is expected of the patient, and to ask questions when there is a lack of understanding. To follow the plan of care established by his/her physician, including the instructions of nurses and other health professionals as they carry out the physician's orders. To keep appointments or notifying the facility or physician when he/she is unable to do so. To be responsible for his/her actions should he/she refuse treatment or not follow his/her physician's orders. To assure that the financial obligations of his/her health care are fulfilled as promptly as possible. To follow facility policies, procedures, rules and regulations. To be considerate of the rights of other patients and facility personnel. To be respectful of his/her personal property and that of other persons in the facility. To help staff to assess pain, request relief promptly, discuss relief options and expectations with caregivers, work with caregivers to develop a pain management plan, tell staff when pain is not relieved, and communicate worries regarding pain medication. To inform the facility of a violation of patient rights or any safety concerns, including perceived risk in his/her care and unexpected changes in their condition.

Effective: February 2018 (Revised June 2021)

OU Health