PATIENT REGISTRATION FORM

Read carefully & complete

Post Office Box 660 · 85 Sierra Park Road · Mammoth Lakes, CA 93546 · 760-934-3311 · Fax 760-924-4029 · www.mammothhospital.com

PATIENT INFORMATION Have you ever been a patient at any Mammoth Hospital facility? Y N

Last Name:_____ First Name: _____ Middle Name: _____

E-mail address _____ Cell Phone # (___)_____

Street Address/City/State/Zip _____

Mailing Address (if different than above) _____Phone(___) _____

City _____ State_____ Zip _____ County_____ Country _____

Birth Date _____ Age _____ Sex _____

Marital Status M S D W Social Security #: _____ Refused *please initial* _____

Any changes in the above section? Yes No Initials _____

Race: _____ *or (circle)* White Native American Other Black Asian Unknown Pacific Islander

Any changes in the above section? Yes No Refused *please initial* _____

Ethnicity: _____ *or (circle)* Hispanic Non-Hispanic Unknown

Any changes in the above section? Yes No Refused *please initial* _____

Primary Language: _____

Employer's Name _____ Phone ___ _____

Employer's Address _____

Occupation_____ Full Time Part Time Self Employed Retired Student

If visiting the area, please leave a local phone # & location where you can be reached:_____

_____

INSURANCE INFORMATION

Primary Insurance: _____ **Secondary Insurance:** _____

Group Policy ***OR*** *Individual Policy* *Group Policy* ***OR*** *Individual Policy*

Address: _____ Address: _____

Telephone # (___) _____ Telephone # (___) _____

ID # _____Group # _____ ID # _____Group # _____

Insured's Name: _____ Insured's Name: _____

Address: _____ Address: _____

Birth Date: _____ Gender M F Birth Date: _____ Gender M F

Employer's name: _____ Employer's name: _____

Address:_____ Address:_____

FT PT Seasonal Retired/Date _____ FT PT Seasonal Retired/Date _____

Occupation _____ Occupation _____

Relationship to Patient: _____ Relationship to Patient: _____

Third Insurance (If any) _____

**** A copy of your insurance card and other ID is required for billing*

Any changes in the above section? Yes No Initials _____

EMERGENCY CONTACT (preferably someone outside of the home) Relationship to patient _____

Name _____

Mailing Address _____ City _____State_____ Zip _____

Home Phone # (___) _____ Work Phone # (___) _____

CONSENT FOR TREATMENT

M.R. #

Patient Name

Date of Birth

Medical and Surgical Consent: The patient is under the control of his/her attending physicians and the Hospital is not liable for any act or omission in following the instructions of said physicians, and the undersigned consents to any x-ray examination, laboratory procedures, anesthesia, medical or surgical treatment or hospital services rendered the patient under the general and special instructions of the physicians. The undersigned recognizes that all medical doctors furnishing services to the patient, including radiologists, pathologists, anesthetists and the like are independent contractors and are not employees or agents of the Hospital.

General Duty Nursing: The Hospital provides only general duty nursing care. Under this system, nurses are called to the bedside of the patient by a signal from the patient. If the patient is in such condition as to need continuous or special duty-nursing care, it is understood that such care must be arranged by the patient, or his/her legal representative, or his/her physicians, and the Hospital shall in no way be responsible for failure to provide the same and is hereby released from any and all liability which may or might arise from the fact that the undersigned patient is not provided with such additional care.

Personal Valuables: It is understood and agreed that the Hospital maintains a safe for the safekeeping of money and valuables and the Hospital shall not be liable for the loss or damage to any money, jewelry, glasses, dentures, documents, furs, fur coats and fur garments or other articles of unusual value and small compass, unless placed therein, and shall not be liable for loss or damage to any other personal property, unless deposited with the Hospital for safekeeping.

Financial Agreement: The undersigned agrees, whether he/she signs as the patient or as agent, that in consideration of the services to be rendered to the patient, he/she hereby obligates himself/herself to pay the account of the Hospital in accordance with its financial terms (attached). Should the account be referred to an attorney or collection agency for collection, the undersigned shall pay actual attorney's fees and collection expenses. All delinquent accounts shall bear interest at the legal rate.

Medicare Assignment of Benefits: If applicable, I certify that the information given by me in applying for payment under Title XVIII (Medicare) of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf.

Assignment of Benefits: I hereby authorize payment directly to Mammoth Hospital of insurance benefits otherwise payable to me for payment of this hospitalization, but not to exceed the Hospital's regular charges. It is agreed that payment to the Hospital pursuant to this authorization by an insurance company, shall discharge said insurance company of any and all obligations under a policy to the extent of such payment. I understand that the Hospital does not accept responsibility for collecting my insurance proceeds or negotiating a settlement on a disputed claim. It is also understood that I am financially responsible for charges not covered by this assignment.

I UNDERSTAND THAT ONCE THIS CONSENT FOR TREATMENT IS SIGNED, IT WILL REMAIN IN EFFECT FOR ALL FUTURE CLINIC VISITS UNTIL REVOKED IN WRITING.

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ THE FOREGOING AND IS THE PATIENT, THE PATIENTS LEGAL GUARDIAN OR IS DULY AUTHORIZED BY THE PATIENT AS THE PATIENT'S GENERAL AGENT TO EXECUTE THE ABOVE AGREEMENT AND ACCEPTS ITS TERMS.

Signature of patient/patient's legal representative

Date

If signed by other than patient, indicate relationship

MAMMOTH HOSPITAL Southern Mono
Healthcare District

FINANCIAL POLICY

Thank You for choosing Mammoth Hospital's Sierra Park Clinics for your health care needs.

The following is a general statement explaining our financial policies.

FINANCIAL AGREEMENT The financial agreement is a contract between you, the patient or responsible party, and the hospital.

USUAL AND CUSTOMARY RATES Fees charged at Mammoth Hospital are usual and customary for our area. You are responsible for payment in full regardless of rate reductions made by your insurance company based on their fee schedule.

INSURANCE

Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Some services provided at Mammoth Hospital may not be deemed reasonable by your insurance company and may therefore be considered "non-covered". Mammoth Hospital will bill your insurance carrier as a courtesy when provided with complete and accurate information. It is YOUR responsibility to make the necessary calls to ensure your insurance company will pay for your treatment. If you are enrolled with an HMO or are assigned to a Primary Care Physician (PCP) or Primary Medical Group (PMG), it is critical that you notify them of your treatment at Mammoth Hospital. READ your insurance card or booklet for specific instructions.

NON-COVERED ITEMS

Non-covered items are services and/or supplies which may be determined by Medi-Cal, CMSP, Medicare or other insurance carriers as not medically necessary for the symptoms, diagnosis and/or treatment of a medical condition. You are financially responsible for ALL services and supplies rendered.

DENIED SERVICES

In the event that all or any portion of an insurance claim is denied by the insurance carrier, the patient/financially responsible party shall be responsible for all charges incurred.

LIMITED COVERAGE If your coverage is for emergency, accident or pregnancy. related services only, you may be responsible for emergency department charges not meeting coverage criteria.

DEFINITION OF EMERGENCY CONDITION

A medical condition that manifests itself by acute symptoms of sufficient severity, including severe pain that in the absence of immediate medical care could reasonably be expected to place the health of the individual or unborn child in serious jeopardy, impairment to bodily functions, or dysfunction of any bodily organ or part.

If you have received services such as anesthesia, emergency physician services, physician specialist consultation, had laboratory or pathology services that were sent to an outside laboratory, or arrived at the hospital via Mono County Paramedics, you will receive a separate bill from those providers. Independent physicians and service providers are not covered by Mammoth Hospital insurance contracts.

NOTE: Medicare recipients may have additional rights not outlined above.

I acknowledge receipt of Mammoth Hospital's Notice of Privacy Practices. This document provides information about how Mammoth Hospital may use and disclose my protected health information.

Once this financial policy is signed, the financial responsibility will remain in effect for all future admissions until revoked in writing.

I have read and understand the above statements. I acknowledge that I am fully responsible for all charges incurred.

Signature of Patient/Financially Responsible Party	Date
Patient Name	If signed by other than patient, indicate relationship

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New Injury Questionnaire

General Information

Primary Care Physician _____ Date _____

Name _____ DOB _____ Age _____
Address _____
City/State/Zip _____
Phone _____ Pager: _____ Fax/Email: _____
Occupation: _____

Work Status: Full Limited Retired Off-work
Since When: _____
Who referred you? Name: _____
Address: _____
Hobbies _____
Athletics _____
:

Present Orthopedic Problem

Which (body part) _____ ? Left Right Is problem work related? Yes No
Auto Accident related? Yes No Is legal action pending? Yes No

Date symptoms began (mm/dd/yy) _____ or Date of injury _____
City _____ State _____ Time of Day _____
If injury, please describe, in detail, how it occurred _____
_____
_____

When does it hurt? Grasping Pulling Pushing Carrying Pinching Gripping Lifting
Overhead lifting Walking Running Standing Squatting Stairs
Neck Mid-back Lowback

In Morning At Night When Sleeping All of the time

What makes it better? _____
What makes it worse? _____
Grade the pain: none 1 2 3 4 5 6 7 8 9 10 severe
What medicine helps? _____
Grade pain after medicine: none 1 2 3 4 5 6 7 8 9 10 severe

Do you have numbness? Yes No Where? _____
Do you have weakness? Yes No Where? _____

Have you seen other doctors/therapists/chiropractors? _____
Have you had physical therapy? Yes No How many sessions? _____

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Cortisone injections? Yes No How many? _____ Date of last one?_____
Did it help? Yes No Only for a short time
X-Rays: Yes No Date: _____ Cat Scans: Yes No Date: _____
MRI: Yes No Date: _____

Related Surgeries:
1)_____ Date _____
2)_____ Date _____
3)_____ Date _____
4)_____ Date _____

Did surgery help? Yes No
If *No*, please explain: _____
_____

Unrelated Past Surgeries
1) _____
2) _____
3) _____
4) _____
5) _____
6) _____
7) _____

Present Medications
1) _____
2) _____
3) _____
4) _____
5) _____
6) _____
7) _____
8) _____

Drug allergies
1) _____
2) _____
3) _____

Medical Information Other unrelated medical problems
1) _____
2) _____
3) _____
4) _____
5) _____
6) _____
7) _____

Smoking History: Packs per day _____
How many years have you smoked?_____

Alcohol history: Drinks per day_____
Drinks per week _____

Have you had in the past five years or are currently experiencing: Please circle all that apply

Seizures Depression Tremors Change of vision Strep throat Thyroid problems
Shortness of breath Steroid use Heart attacks Diabetes Stomach ulcers Jaundice Gout
Painful Urination Kidney stones Multiple Fractures Easy bleeding Insomnia Drug Dependency
Dizzy spells Severe headaches Chronic rashes Hypertension Asthma/Pneumonia Diarrhea
High cholesterol Chest pain Bloody/Black stool Bloody urine Sexual disease Multiple joint aches
Rheumatoid arthritis Recent weight loss Anesthesia problems Change in hearing

Please explain circled items: _____
_____
_____

Patient signature _____

PRE-ADMISSION QUESTIONNAIRE

MAMMOTH HOSPITAL
Southern Mono Healthcare District USSA

Date: _____

This is a questionnaire that is used to assist the medical team in giving you the most efficient and highest quality care possible. We ask that you answer each question to the best of your ability.

NAME: _____ AGE: _____ ALLERGIES: _____
HEIGHT: _____ WEIGHT: _____ RECENT GAIN OR LOSS: _____
EMERGENCY CONTACT: _____ PHONE: _____

Do You ...	Yes	No
WEAR GLASSES		
WEAR CONTACT LENSES		
HAVE A HEARING AID		
WEAR DENTURES		
HAVE A SPECIAL DIET		
EXERCISE REGULARLY		
EXERCISE MINIMALLY		

DO YOU SMOKE/USE TOBACCO? YES / NO
WHAT TYPE(S): _____
OF YEARS SMOKED/USED: _____
HOW MUCH/DAY OR WEEK: _____
QUIT DATE: _____

DO YOU DRINK ALCOHOL? YES / NO
OF DRINKS: _____/DAY OR _____/MONTH
TYPE: BEER /WINE/ LIQUOR

PLEASE LIST YOUR EXERCISE ACTIVITIES AND FREQUENCIES: _____

IF YOU DO NOT PARTICIPATE IN REGULAR EXERCISE ACTIVITIES, PLEASE ANSWER A-C:

a) CAN YOU COMPLETE HOUSEHOLD CHORES W/OUT BECOMING UNUSUALLY SHORT OF BREATH OR EXPERIENCING CHEST PAIN? YES / NO
b) CAN YOU WALK UP 2 FLIGTS OF STAIRS W/OUT BECOMING UNUSUALLY SHORT OF BREATH OR EXPERIENCING CHEST PAIN? YES / NO
c) CAN YOU WALK MORE THAN 2 CITY BLOCKS W/OUT BECOMING UNUSUALLY SHORE OF BREATH OR EXPERIENCING CHEST PAIN? YES / NO

MEDICAL HISTORY

BLOOD DISORDERS: YES/ NO
(Anemia, excessive bleeding) HIGH
BLOOD PRESSURE: YES / NO

DIABETES: YES/ NO
CANCER: YES / NO
SEIZURES: YES/ NO

HEART DISEASE: YES / NO
RESPIRATORY PROB: YES / NO ANY
ANESTHESIA PROBLEMS: YES / NO

PLEASE EXPLAIN IF ANY MEDICAL HISTORY PROBLEMS: _____

MEDICATIONS YOU TAKE: _____

PLEASE LIST ANY PREVIOUS SURGERIES, HOSPITALIZATIONS, MAJOR ILLNESSES, AND THE DATES: _____

HAVE YOU EVER HAD A HEART EXERCISE STRESS TEST? YES/NO LAST EXAM DATE: _____
HAVE YOU EVER HAD A HEART CATHETIZATION? YES/NO

WHEN WAS YOUR LAST ...
PHYSICAL EXAM: _____
CHEST X-RAY: _____
EKG _____
LAB WORK: _____

(FEMALES)
DATE OF LAST MENSTRUAL PERIOD: _____
HISTORY OF HEAVY PERIODS? Yes / No
RECENT PREGNANCY/DELIVERY? Yes / No
ARE YOU PREGNANT NOW? Yes / No

PLEASE GIVE BRIEF HISTORY & DESCRIPTION OF YOUR PRESENT PROBLEM & YOUR UNDERSTANDING OF WHAT YOUR PHYSICIAN PLANS TO DO? _____

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Mammoth Hospital Notice of Privacy Practices

As Required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AS WELL AS HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY

A. UNDERSTANDING YOUR MEDICAL RECORD AND HEALTH INFORMATION

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, and a plan for future care or treatment. This information, often referred to as your medical or health record, serves as a:

- Basis for planning your care and treatment;
- Means of communication among the health professionals who contribute to your care;
- Legal document describing the care you received;
- Means by which you or a third-party payer can verify that services billed were actually provided;
- Tool in educating heath professional;
- Source of data for medical research;
- Source of information for public health officials charged with improving the health of the nation;
- Source of data for facility planning and marketing;
- Tool with which we can assess and continually work to improve the care we render and the outcomes we achieve;
- Understanding what is in your record and how your health information is used helps you to ensure its accuracy;
- Better understand who, what, when, where, and why others may access your health information;
- Make more informed decisions when authorizing disclosure to others.

B. OUR COMMITMENT TO YOUR PRIVACY

Mammoth Hospital is dedicated to maintaining the privacy of your health information. In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your health information. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time. We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your health information;
- Your privacy rights in regard to your health information;
- Our obligations concerning the use and disclosure of your health information.

The terms of this notice apply to all records containing your health information that are created or retained by Mammoth Hospital. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Mammoth Hospital will post a copy of our current Notice in our offices in a visible location at all times, on our website, and you may request a copy of our most current Notice at any time.

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C. OUR RESPONSIBILITIES

Mammoth Hospital is required to:

- Maintain the privacy of your health information;
- Provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you;
- Abide by the terms of this notice;
- Notify you if we are unable to agree to a requested restriction;
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you've supplied us. We will not use or disclose your health information without your authorization, except as described in this notice.

D. HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION:

The following categories describe different ways that we may use and disclose health information. Not every use and disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

Treatment: We may use your health information to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your health information in order to write a prescription for you, or we might disclose your health information to a pharmacy when we order a prescription for you. Many of the people who work for our practice including, but not limited to, our doctors and nurses, may use or disclose your health information in order to treat you or to assist others in your treatment. Additionally, we may disclose your health information to others who may assist in your care, such as your spouse, children or parents.

Payment: We may use and disclose your health information in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your health information to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your health information to bill you directly for services and items.

Health Care Operations: Members of the medical staff, the risk or utilization review manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and services we provide.

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, and certain laboratory tests. When these services are contracted, we may disclose your health information to our business associate 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, we require the business associate to appropriately safeguard your information.

Hospital Directory: Unless you notify us that you object, we will use your name, location in the facility, general condition, and religious affiliation for directory purposes. This information may be provided to members of the clergy and, except for religious affiliation, to other people who ask for you by name. This information is released so your family, friends and clergy can visit you in the hospital and generally know how you are doing.

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Appointment Reminders: We may use and disclose your health information to contact you as a reminder that you have an appointment for treatment or medical care at the hospital.

Treatment Alternatives: We may use and disclose your health information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.
Health-Related Products and Services: We may use and disclose health information to tell you about our health-related products or services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care: We may use or disclose information about you to a friend or family member who is involved in your medical care. For example, a parent or guardian may ask that a babysitter take their child to the pediatrician's office for treatment of a cold. In this example, the babysitter may have access to this child's health information. We may also give information to someone who helps pay for your care. Unless there is a specific written request from you to the contrary, we may also tell your family or friends your condition and that you are in the hospital. In addition, we may disclose information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

Fundraising: We may contact you in an effort to raise money for the hospital and its operations. We may disclose information to a foundation related to the hospital so that the foundation may contact you in raising money for the hospital. We will only release contact information, such as your name, address and phone number and the dates you received treatment or services at the hospital. If you do not want the hospital to contact you for fundraising efforts you must notify us in writing. See the end of this document for the address.

Research: Under certain circumstances, we may use and disclose health information about you for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another, for the same condition. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of health information, trying to balance the research needs with the patients' need for privacy of their health information. Before we use or disclose health information for research, the project will have been approved through this approval process, but we may, disclose health information about you to people preparing to conduct a research project, for example, to help them look for patients with specific medical needs, so long as the health information they review does not leave the hospital. We will almost always ask for your specific permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care at the hospital.

Coroners, Medical Examiners and Funeral Directors: We may release health information to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

Organ Procurement Organizations: Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Workers' compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs established by law. These programs provide benefits for work-related injuries or illness.

Public Health Activities: As required by law, we may disclose health information about you for public health activities. These activities include disclosures in order to:

- Prevent or control disease, injury or disability;
- Report births and deaths;
- Report the abuse or neglect of children, elders and dependent adults;
- Report reactions to medications or problems with products;
- Notify people of recalls of products they may be using;

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- Notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities: We may disclose health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Mammoth Mountain: Should your care at Mammoth Hospital result from an accident sustained during recreational activities at Mammoth Mountain, we may disclose limited health information in order for Mammoth Mountain to perform their own quality and outcome improvement activities.

Ambulance/Air Transport: Should you need to be transferred from/to Mammoth Hospital, we may disclose limited health information to the transporting company for their own billing and/or quality and outcome improvement activities.

Manufacturers of implants and Devices: We may disclose limited health information to the manufacturers of implants and devices you acquire due to treatment at the hospital. For example, the manufacturer of hardware used for internal fixations of fractures will be given health information for tracking purposes in the event a product is recalled.

Military and Veterans: if you are a member of the armed forces, we may release health information about you as required by military command authorities. We may also release health information about foreign military personnel to the appropriate foreign military authority.

Correctional Institution: if you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose health information about you to the correctional institution or law enforcement official. This disclosure would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Lawsuits and Disputes: if you are involved in a lawsuit or dispute, we may disclose health information about you in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request (as shown by a written notice to you) or to obtain an order protecting the information requested.

National Security and Intelligence Activities: We may disclose health information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Law enforcement: We may disclose health information if asked to do so by a law enforcement official:

- In response to a court order, subpoena, warrant, summons or similar process;
- To identify or locate a suspect, fugitive, material witness, or missing person;
- About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
- About a death we believe may be the result of criminal conduct;
- About criminal conduct at the hospital;
- In emergency circumstance to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

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E. YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

You have the following rights regarding the health information that we maintain about you:

Confidential Communications: You have the right to request that Mammoth Hospital communicate with you about your health and related issues in a particular manner or at a certain location. For example, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate reasonable requests. You do not need to give a reason for your request. See the end of this document for the address.

Requesting Restrictions: You have the right to request a restriction in our use or disclosure of your health information for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your health information, you must make your request in writing. See the end of this document for the address.

Your request must describe in a clear and concise fashion (1) the information you wish restricted; (2) whether you are requesting to limit our practice's use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

Inspection and Copies: You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient health records and billing records. You must submit your request in writing in order to inspect and/or obtain a copy of your health information. Mammoth Hospital may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Mammoth Hospital may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

Amendment: You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for Mammoth Hospital. To request an amendment your request must be made in writing. See the end of this document for the address.

You must provide us with a reason that supports your request for amendment. Mammoth Hospital will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the health information kept by or for the practice; (c) not part of the health information which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information. Even if we deny your request for amendment, you have the right to submit a written addendum, not to exceed 250 words, with respect to any item or statement in your record you believe is incomplete or incorrect. If you clearly indicate in writing that you want the addendum to be made part of your health record we will attach it to your records and include it whenever we make a disclosure of the item or statement you believe to be incomplete or incorrect.

Post Office Box 660 - 85 Sierra Park Road - Mammoth Lakes, CA 93546 - 760-934-3311 - Fax 760-934-1832 - www.mammothhospital.com

Accounting of Disclosures: All of our patients have the right to request an "accounting of disclosures" An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your health information for non-treatment or operations purposes.
Use of your health information as part of the routine patient care in Mammoth Hospital is not required to be documented. For example, a doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing. See the end of this document for the address.
All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Mammoth Hospital will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

Right to a Paper Copy of This Notice: You are entitled to receive a paper copy of this notice. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact Mammoth Hospital at the address at the end of this document.

You may also obtain a copy of this notice at our website: www.mammothhospital.com

Right to File a Complaint: Maintaining the confidentiality of the health information of our patients is of the utmost importance. If you believe your privacy rights have been violated, you may file a complaint with the Mammoth Hospital Privacy Officer. All complaints must be submitted in writing. You will not be penalized for filing a complaint. See the end of this document for the address.

You may always file a complaint with the Secretary of the Department of Health and Human Services.

Right to Provide an Authorization for Other Uses and Disclosures: Mammoth Hospital will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your health information may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your health information for the reasons described in the authorization.

Again, if you have any questions regarding this notice or our health information privacy policies, please contact:

Mammoth Hospital
Privacy Officer
P.O. Box 660
Mammoth Lakes, CA 93546
(760) 934-3311

Mammoth Hospital
Health Information Management System
P.O. Box 660
Mammoth Lakes, Ca. 93546
(760) 934-3311

Effective Date: 04/14/2003