



**Notice of Privacy Practices**

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

Effective Date January 1, 2017

**A. PURPOSE OF THIS NOTICE.**

Oregon Health & Science University (“OHSU”) is committed to preserving the privacy of your health information. In fact, we are required by law to do so for any health information created or received by us. OHSU is required to provide this Notice of Privacy Practices (“Notice”) to you. The Notice tells you how we can and cannot use and disclose the health information that you have given to us or that we have learned about you when you were a patient in our system. It also tells you about your rights and our legal duties concerning your health information.

OHSU is required to abide by this Notice and any future changes to the Notice that we are required or authorized by law to make at all OHSU locations, including the schools of Dentistry, Medicine, Nursing, and Science & Engineering; OHSU Hospital, and Doernbecher Children’s Hospital; numerous primary care and specialty clinics; multiple research institutes and centers; and several community service and outreach programs. This Notice applies to the practices of:

- All OHSU employees, volunteers, students, residents and service providers, including clinicians, who have access to health information.
- Any health care professional authorized to enter information into your OHSU health record.
- Any non-OHSU clinicians who might otherwise have access to your health information created or kept by OHSU, as a result of, for example, their call coverage for OHSU clinicians.

For the rest of this Notice, “OHSU,” “we” and “us” will refer to all services, service areas, and workers of OHSU. When we use the words “your health information,” we mean any information that you have given us about you and your health, as well as information that we have received while we have taken care of you (including health information provided to OHSU by those outside of OHSU).

We will have a copy of the current Notice with an effective date in clinical locations and on our website at <http://www.ohsu.edu/xd/about/services/integrity/ips/npp.cfm>.

**B. USES AND DISCLOSURES OF HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS AT OHSU.**

**1. Treatment, Payment and Health Care Operations.**

The following section describes different ways that we use and disclose health information for treatment, payment and health care operations. For each of those categories, we explain what we mean and give one or more examples. Not every use or disclosure will be noted and there may be incidental disclosures that are a byproduct of the listed uses and disclosures. The ways we use and disclose health information will fall within one of the categories.

**a. For Treatment.** We may use your health information to provide you with medical or dental treatment or services. We may disclose your health information to staff physicians, staff dentists, post-graduate fellows, midwives or nurse practitioners, and other personnel involved in your health care. We may also disclose your health information to students and resident physicians who, as a part of their OHSU educational programs (and while supervised by physicians or dentists), are involved in your care. Treatment includes (a) activities performed by nurses, office staff, hospital staff, technicians and other types of health care professionals providing care to you or coordinating or managing your care with third parties, (b) consultations with and between OHSU providers and other health care providers, and (c) activities of non-OHSU providers or other providers covering an OHSU practice by telephone or serving as the on-call provider.

For example, a physician or dentist treating you for an infection may need to know if you have other health problems that could complicate your treatment. That provider may use your medical history to decide what treatment is best for you. They may also tell another provider about your condition so that he or she can decide the best treatment for you.

**b. For Payment.** We may use and disclose your health information so that we may bill and collect payment from you, an insurance company, or someone else for health care services you receive from OHSU. We may also tell your health plan about a treatment you are going to receive to obtain prior approval, or to determine whether your plan will pay for the treatment.

For example, we may need to give your health plan information about surgery you received at OHSU so your health plan will pay us or reimburse you for the surgery.

**c. For Health Care Operations.** We may use and disclose your health information in order to run the necessary administrative, educational, quality assurance and business functions at OHSU.

For example, we may use your health information to evaluate the performance of our staff in caring for you. We may also use health information about patients to help us decide what additional services we should offer, how we can improve efficiency, or whether certain treatments are effective. Or we may give health information to doctors, nurses, technicians, or health profession students for review, analysis and other teaching and learning purposes.

**2. Fundraising Activities.**

As a part of OHSU’s healthcare operations, we may use and disclose a limited amount of your health information internally, or to the OHSU Foundation and Doernbecher Children’s Hospital Foundation (collectively, “Foundations”) to allow them to contact you to raise money for OHSU. The health information released for these fundraising purposes can include your name, address, other contact information, gender, age, date of birth, dates on which you received service, health insurance status, the outcome of your treatment at OHSU and your treating physician’s name and department at OHSU. Any fundraising communications you receive from OHSU or its Foundations will include information on how you can elect not to receive any further fundraising communications from OHSU.



**3. Uses and Disclosures You Can Limit.**

**a. Hospital Directory.** Unless you notify us that you object, we may include certain information about you in the hospital directory in order to respond to inquiries from friends, family, clergy and others who inquire about you when you are a patient in the hospital. Specifically, your name, location in the hospital and your general condition (e.g., good, fair, serious, critical) may be released to people who ask for you by name. In addition, your religious affiliation may be given to a member of the clergy, such as a priest or rabbi, even if they don't ask for you by name.

**b. Family and Friends.** Unless you notify us that you object, we may provide your health information to individuals, such as family and friends, who are involved in your care or who help pay for your care. We may do this if you tell us we can do so, or if you know we are sharing your health information with these people and you don't stop us from doing so. There may also be circumstances when we can assume, based on our professional judgment, that you would not object. For example, we may assume you agree to our disclosure of your information to your spouse if your spouse comes with you into the exam room during treatment.

Also, if you are not able to approve or object to disclosures, we may make disclosures to a particular individual (such as a family member or friend), that we feel are in your best interest and that relate to that person's involvement in your care. For example, we may tell someone who comes with you to the emergency room that you suffered a heart attack and provide updates on your condition. We may also make similar professional judgments about your best interests that allow another person to pick up such things as filled prescriptions, medical supplies and X-rays.

**C. OTHER PERMITTED USES AND DISCLOSURES OF HEALTH CARE INFORMATION.**

We may use or disclose your health information without your permission in the following circumstances, subject to all applicable legal requirements and limitations:

1. **Required By Law.** As required by federal, state, or local law.
2. **Public Health Activities.** For public health reasons in order to prevent or control disease, injury or disability; or to report births, deaths, suspected abuse or neglect, nonaccidental physical injuries, reactions to medications, school immunizations under certain circumstances or problems with products.
3. **Victims of Abuse, Neglect or Domestic Violence.** To a government authority authorized by law to receive reports of abuse, neglect or domestic violence when we reasonably believe you are the victim of abuse, neglect or domestic violence and other criteria are met.
4. **Health Oversight Activities.** To a health oversight agency for audits, investigations, inspections, licensing purposes, or as necessary for certain government agencies to monitor the health care system, government programs, and compliance with civil rights laws.
5. **Lawsuits and Disputes.** In response to a subpoena, discovery request or a court or administrative order, if certain criteria are met.
6. **Law Enforcement.** To a law enforcement official for law enforcement purposes as required by law; in response to a court order, subpoena, warrant, summons or similar process; for identification and location purposes if requested; to respond to a request for information on an actual or suspected crime victim; to report a crime in an emergency; to report a crime on OHSU premises; or to report a death if the death is suspected to be the result of criminal conduct.

**7. Coroners, Medical Examiners and Funeral Directors.** To a coroner or medical examiner, (as necessary, for example, to identify a deceased person or determine the cause of death) or to a funeral director, as necessary to allow him/her to carry out his/her activities.

**8. Organ and Tissue Donation.** To organizations that handle organ procurement or organ, eye or tissue transplantation, or to an organ donation bank, as necessary to facilitate a donation and transplantation.

**9. Research.** For research purposes under certain limited circumstances. Research projects are subject to a special approval process. Therefore, we will not use or disclose your health information for research purposes until the particular research project, for which your health information may be used or disclosed, has been approved through this special approval process.

**10. Serious Threat to Health or Safety; Disaster Relief.** To appropriate individual(s)/organization(s) when necessary (i) to prevent a serious threat to your health and safety or that of the public or another person, or (ii) to notify your family members or persons responsible for you in a disaster relief effort.

**11. Military.** To appropriate domestic or foreign military authority to assure proper execution of a military mission, if required criteria are met.

**12. National Security; Intelligence Activities; Protective Service.** To federal officials for intelligence, counterintelligence, and other national security activities authorized by law, including activities related to the protection of the President, other authorized persons or foreign heads of state, or related to the conduct of special investigations.

**13. Inmates.** To a correctional institution (if you are an inmate) or a law enforcement official (if you are in that person's custody) as necessary (a) to provide you with health care; (b) to protect your or others' health and safety; or (c) for the safety and security of the correctional institution.

**14. Workers' Compensation.** As necessary to comply with laws relating to workers' compensation or similar work-related injury program.

**D. WHEN WRITTEN AUTHORIZATION IS REQUIRED.**

Other than for those purposes identified above in Sections B and C, we will not use or disclose your health information for any purpose unless you give us your specific written authorization to do so. Special circumstances that require an authorization include most uses and disclosures of your psychotherapy notes, certain disclosures of your test results for the human immunodeficiency virus or HIV, uses and disclosures of your health information for marketing purposes that encourage you to purchase a product or service, and for sale of your health information with some exceptions. If you give us authorization, you can withdraw this written authorization at any time. To withdraw your authorization, deliver or fax a written revocation to OHSU Health Information Management, Mail Code OP17A, 3181 S.W. Sam Jackson Park Road, Portland, OR 97239; fax: (503) 494-6970. If you revoke your authorization, we will no longer use or disclose your health information as allowed by your written authorization, except to the extent that we have already relied on your authorization.



**E. YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION.**

You have certain rights regarding your health information which we list below. In each of these cases, if you want to exercise your rights, you must do so in writing by completing a form that you can obtain from the OHSU Information Privacy and Security Office, Mail Code ITG09, 3181 S.W. Sam Jackson Park Road, Portland, OR 97239, or on the Web at <http://www.ohsu.edu/xd/about/services/integrity/policies/ips-policies-hipaa-forms.cfm#results>. In some cases, we may charge you for the costs of providing materials to you. You can get information about how to exercise your rights and about any costs that we may charge for materials by contacting the OHSU Information Privacy and Security Office at (503) 494-0219.

**1. Right to Inspect and Copy.** With some exceptions, you have the right to inspect and get a copy of the health information that we use to make decisions about your care. For the portion of your health record maintained in our electronic health record, you may request we provide that information to or for you in an electronic format. If you make such a request, we are required to provide that information for you electronically (unless we deny your request for other reasons). We may deny your request to inspect and/or copy in certain limited circumstances, and if we do this, you may ask that the denial be reviewed.

**2. Right to Amend.** You have the right to amend your health information maintained by or for OHSU, or used by OHSU to make decisions about you. We will require that you provide a reason for the request, and we may deny your request for an amendment if the request is not properly submitted, or if it asks us to amend information that (a) we did not create (unless the source of the information is no longer available to make the amendment); (b) is not part of the health information that we keep; (c) is of a type that you would not be permitted to inspect and copy; or (d) is already accurate and complete.

**3. Right to an Accounting of Disclosures.** You have the right to request a list and description of certain disclosures by OHSU of your health information.

**4. Right to Request Restrictions.** You have the right to request a restriction or limitation on the health information we use or disclose about you (a) for treatment, payment, or health care operations, (b) to someone who is involved in your care or the payment for it, such as a family member or friend, or (c) to a health plan for payment or health care operations purposes when the item or service for which OHSU has been paid out of pocket in full by you or someone on your behalf (other than the health plan). For example, you could ask that we not use or disclose information about a surgery you had, a laboratory test ordered or a medical device prescribed for your care. Except for the request noted in 4(c) above, we are not required to agree to your request. Any time OHSU agrees to such a restriction, it must be in writing and signed by the OHSU Privacy Officer or his or her designee.

**5. Right to Request Confidential Communications.** You have the right to request that we communicate with you about health matters in a certain way or at a certain place. OHSU will accommodate reasonable requests. For example, you can ask that we only contact you at work or by mail.

**6. Right to a Paper Copy of This Notice.** You have the right to a paper copy of this Notice, whether or not you may have previously agreed to receive the Notice electronically.

**7. Right to be Notified of a Breach.** You have the right to be notified if there is a breach - a compromise to the security or privacy of your health information - due to your health information being unsecured. OHSU is required to notify you within 60 days of discovery of a breach.

**F. REVISIONS TO THIS NOTICE.**

We have the right to change this Notice and to make the revised or changed Notice effective for health information we already have about you, as well as any information we receive in the future. Except when required by law, a material change to any term of the Notice may not be implemented prior to the effective date of the Notice in which the material change is reflected. OHSU will post the revised Notice at OHSU clinical locations and on its website and provide you a copy of the revised notice upon your request.

**G. QUESTIONS OR COMPLAINTS.**

If you have any questions about this Notice, please contact OHSU (503) 494-8311. If you believe your privacy rights have been violated, you may file a complaint with OHSU or with the Secretary of the Department of Health and Human Services. To file a complaint with OHSU, contact OHSU at (503) 494-8311. You will not be penalized for filing a complaint.

This Notice tells you how we may use and share health information about you. If you would like a copy of this Notice, please ask your health care provider.

**Inclusive Patient Care and Communication**

**OHSU IS COMMITTED TO PROVIDING INCLUSIVE PATIENT CARE.**

OHSU complies with applicable state and federal civil rights laws and does not discriminate, exclude people or treat them differently on the basis of:

- Race
- National origin
- Disability; or
- Color
- Age
- Sex.

**WE ARE HAPPY TO HELP YOU WITH COMMUNICATION AIDS AND LANGUAGE ACCESS.**

OHSU provides free auxiliary aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats and other formats)

OHSU also provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact your care provider's office. They will make the language services arrangements for you. OHSU offers free language services in over 120 languages



**WE ARE HERE TO HELP YOU WITH YOUR CONCERNS.**

If you believe that OHSU has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance in writing with the Patient Advocate at the Patient Relations Office, 3181 SW Sam Jackson Park Road, Mail Code: UHS-3, Portland OR 97239, Phone: 503-494-7959, Fax: 503-494-3495, Email: [advocate@ohsu.edu](mailto:advocate@ohsu.edu). You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, the Patient Advocate is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, D.C. 20201, 1-800-868-1019, 800-537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

**Español (Spanish)**

Si usted habla español, contamos con servicios de asistencia de idiomas, sin costo, disponibles para usted. Si necesita estos servicios, comuníquese al consultorio de su proveedor de atención médica. Ellos gustosamente coordinarán los servicios de idiomas para usted.

**Tiếng Việt (Vietnamese)**

Nếu bạn nói tiếng Việt, dịch vụ hỗ trợ ngôn ngữ, miễn phí, có sẵn dành cho bạn. Nếu bạn cần những dịch vụ này, hãy liên lạc văn phòng của bác sĩ chăm sóc của bạn. Họ sẽ sẵn sàng thu xếp các dịch vụ ngôn ngữ cho bạn.

**日本語 (Japanese)**

あなたの母語が日本語であれば、言語サポートサービスを無料にてご用意しています。サービスをご希望の場合には、あなたのケアプロバイダー事務所までご連絡ください。喜んで言語サポートサービスの手配をいたします。

**العربية (Arabic)**

إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية متاحة لك مجاناً. إذا كنت تحتاج إلى هذه الخدمات، فاتصل بمكتب مقدم الرعاية الخاص بك. سيكون الموظفون هناك سعداء بإجراء الترتيبات المتعلقة بالخدمات اللغوية من أجلك.

**Română (Romanian)**

Dacă vorbiți română, puteți beneficia de asistență lingvistică gratuită. Dacă aveți nevoie de astfel de servicii, luați legătura cu biroul furnizorului dvs. de servicii medicale. Reprezentanții acestuia vă vor ajuta cu plăcere să beneficiați de asistență lingvistică.

**中文 (Chinese-Simplified)**

如果您说中文，可为您提供免费的语言援助服务。如果您需要这些服务，请联系您保健提供者的办公室。他们将乐意为您安排语言服务。

**Русский (Russian)**

Если вы говорите на русском языке, вам могут предоставить бесплатные услуги переводчика. Если вам требуются такие услуги, обратитесь в офис своего поставщика медицинских услуг. Сотрудники с радостью предоставят вам переводчика!

**한국어 (Korean)**

한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 이 서비스가 필요하시면 귀하의 의료 제공자 사무실에 연락하십시오. 귀하를 위해 기꺼이 언어 서비스를 준비해드릴 것입니다.

**Українська (Ukrainian)**

Якщо ви розмовляєте українською мовою, послуги мовної допомоги доступні для вас безкоштовно. Якщо вам потрібні ці послуги, зв'яжіться з офісом вашого постачальника послуг. Вони будуть раді надати вам послуги мовної допомоги.

**មន-ខ្មែរ (Mon-Khmer Cambodian)**

ប្រសិនបើលោកអ្នកនិយាយភាសា មន-ខ្មែរ, ភាសាខ្មែរ នោះសំណើជំនួយជូនកែភាសាមានជូនជូនលក់អ្នកដោយឥតគិតថ្លៃ។ ប្រសិនបើលោកអ្នក គួរការសំណើទាំងនេះ សូមទំនាក់ទំនងទៅកាន់ការិយាល័យអ្នកជូនជូនការថែទាំរបស់លោកអ្នក។ ពួកគេ ពេញចិត្តក្នុងការរៀបចំសំណើជូនកែភាសាជូនដល់ ឲ្យសម្រាប់លោកអ្នក។

**LANGUAGE SERVICES NOTIFICATION:  
TRANSLATIONS FOR MOST-SPOKEN LANGUAGES IN OREGON.**

Language assistance services (in person, live over the phone or live video) are available to you free of charge upon request. Please let your provider's office staff know that you need language services for your visit.

**English**

If you speak [insert language], language assistance services, free of charge, are available to you. Call your care provider's office and they are happy to make the language services arrangements for you.

**Oroomiffa (Oromo)**

Afaan Kuush (Oromoo) , dubbattu yoo ta'e, tajaajilliwwan deeggarsa afaanii, kaffaltii irraa bilisa ta'an, isiniif ni jiraatu.Tajaalilawwan kanneen ni barbaaddu yoo ta'e , wajjira dhiyeessaa deeggarsa keessanii qunnamaa. Isaan gammachuudhaan tajaajilawwan afaanii isiniif mijeessu.

**Deutsch (German)**

Wenn Sie Deutsch sprechen, stehen für Sie kostenlos Sprachassistentendienste zur Verfügung. Wenn Sie diese Dienste in Anspruch nehmen möchten, wenden Sie sich bitte an das Büro Ihres Leistungserbringers. Dort wird man die Sprachassistentendienste gerne für Sie arrangieren.

**فارسی (Farsi)**

اگر به زبان فارسی صحبت می کنید، سرویس کمک زبانی به صورت رایگان در دسترس شما خواهد بود. اگر به این سرویس نیاز دارید، با دفتر ارائه دهنده خدمات تماس بگیرید. آنها حتماً مقدمات لازم را برای دسترسی به سرویس های زبانی در اختیارتان قرار می دهند.

**Français (French)**

Si vous parlez français, des services d'aide linguistique gratuits sont à votre disposition. Si vous nécessitez ces services, contactez le cabinet de votre prestataire de soins. Ils se feront un plaisir d'organiser ces services linguistiques pour vous.

**ไทย (Thai)**

หากท่านพูดภาษาไทย จะมีบริการความช่วยเหลือทางด้านภาษาโดยไม่ค่าใช้จ่าย หากท่านต้องการใช้บริการดังกล่าว โปรดติดต่อสำนักงานผู้ให้บริการดูแล ซึ่งพร้อมที่จะจัดหาบริการทางด้านภาษาให้แก่ท่าน



**Terms and Conditions of Service**

TC-OP 1413 effective 4/13

**CONSENT FOR TREATMENT**

**HEALTH CARE CONSENT:** I request and agree to receive all services provided by the health care professionals authorized to care for me at OHSU. I understand that these services may include:

- Services provided under the supervision, direction or instruction of attending physicians and other authorized health care professionals.
- Routine procedures used for diagnosis.
- Additional or related treatments and procedures my OHSU providers determine are necessary and in my best interest.

I also understand:

- There may be risks and alternatives to a particular treatment or procedure my health care provider recommends or prescribes.
- My health care provider may need to explain and discuss with me certain treatments or procedures. He or she also may need to ask for my consent before performing them.
- It is important to ask questions or ask for more information about the care or treatment I may receive at OHSU.

I understand the practice of medicine, surgery and dentistry is not an exact science. I have not received any promises or guarantees about the results I may expect from my care at OHSU.

**TEACHING/RESEARCH:** OHSU is an academic research center and all human research undergoes an ethical review process. I understand that OHSU health care providers or clinical researchers may contact me to ask me if I would like to volunteer to take part in educational or clinical research projects that require consent.

I understand that OHSU is a teaching institution, and that attending staff providers direct the care provided at OHSU. As part of OHSU's education programs and activities, students, resident physicians, post-graduate fellows or others involved in undergraduate and graduate health care education programs may watch and/or take part in the care or procedures I receive at OHSU.

I understand I can refuse to participate in education programs and activities, and my refusal will not affect my care at OHSU.

**STATEMENT OF FINANCIAL RESPONSIBILITY**

**FINANCIAL AGREEMENT:** If I have health insurance, I understand that the terms of my health insurance or health benefit plan(s) may reduce, limit or control what I am required to pay OHSU for the services I receive at OHSU. Whether or not I have health insurance, I agree to be financially responsible and pay for the services provided to me by OHSU if the services are not covered or fully paid for by Insurance and the law allows OHSU to collect from me the amount owing. I also agree to pay OHSU's reasonable costs for collecting payments if I do not pay on time the amounts I am responsible for paying. These collection costs may include reasonable attorney fees whether or not legal action has been filed or appealed.

**ASSIGNMENT:** I assign to OHSU and/or OHSU Medical Group the right to receive benefit payments directly from my health insurance or health plan for reimbursement of the hospital, physicians and other services I receive at OHSU. I understand this assignment is final.

I authorize my health insurance and health plans to make payments directly to OHSU. OHSU Hospital, Faculty Practice Plan, Faculty Dental Practice, or other related professional billing services. I understand the payments from my health insurance or plan for services provided to me at OHSU will be applied to my patient account balance and total financial responsibility. I agree to pay within 30 days following OHSU's notification any charges I owe which are not covered and paid by insurance(s).

**SOCIAL SECURITY PROGRAMS:** I certify the information I gave when I applied for Medicare and/or Medicaid benefits (and payment under Titles V, XVIII, or XIX of the Social Security Act) is correct. If these benefits end, I understand I will receive a notice and I will then be responsible for paying for hospital care if I choose to stay in the hospital and/or continue to receive services. I request that payment of authorized benefits be made on my behalf directly to the provider. If I have not signed up for any Medicare and/or Medicaid benefits (and payment under Titles V, XVIII, or XIX of the Social Security Act), I agree that if/when I do sign up for such benefits, I agree I will provide accurate information and that this paragraph shall apply to me upon my application for Medicare and/or Medicaid benefits.



**OTHER**

**SOCIAL SECURITY NUMBERS:** I understand that OHSU collects administrative and nonmedical patient information including Social Security numbers to identify patients, comply with federal and state reporting requirements, bill insurance carriers, and collect payments, as authorized by ORS 351.070 and 353.050. I understand I do not have to give OHSU my Social Security number. If I provide this information, I authorize OHSU to use it for the purposes listed above.

**CLAIMS:** I understand that each person is responsible to be informed about laws that affect him or her. I also understand, however, that OHSU wishes to alert me to a limitation in the law that relates to OHSU: Because OHSU is a public body, Oregon law may limit the dollar amount that a person may recover from OHSU or its caregivers for a claim relating to care at OHSU, and the time within which a person may bring a claim. If I have any questions about this, I understand that I am free to ask or seek advice from any independent person or source.

**TELEPHONE COMMUNICATION:** By signing this document, I expressly give OHSU, its affiliates, agents, and contractors consent to contact me using an auto dialer, prerecorded message, live operator, or other means at any telephone number or any contact information for any other communication device that I provide for treatment, payment, or other health care operations purposes, as those terms are defined in 45 CFR 164.501, as long as such contact complies with applicable law.

**The following information is specific to the OHSU Hospitals:**

**PERSONAL BELONGINGS:** I agree OHSU is not liable for losing or damaging personal property I bring into OHSU.

**RECEIPT OF "AN IMPORTANT MESSAGE FROM MEDICARE":** Yes  No



## FDP Patient Information and Agreement

Effective 9/2017

### **Patient Information:**

1. **Conduct:** All patients must agree to conduct themselves in a courteous and respectful manner. We do not tolerate inappropriate behavior from patients or visitors.
2. **Records:** The patient or parent/guardian may request copies of clinical records, including radiographic images, by completing the appropriate form and payment of a processing fee. It will take 1-3 weeks to process this request.
3. **Patient Availability:** During the course of treatment, the patient must be available for appointments depending on the dental provider and clinic schedules.
4. **Appointment Cancellation Policy:** The Faculty Dental Practice will give an appointment reminder 2-3 days before the scheduled appointment via email or phone. The patient is responsible for giving 48 hours advance notice to cancel or reschedule an appointment. If appropriate notice is not given, a "No Show" charge of \$50.00 will be added to your account to offset the preparation and resetting time for your treatment room.
5. **Payment Options:**
  - a. Option 1: For any procedure that requires two appointments, pay half of the treatment fee (or estimated "patient portion" if insurance will be billed) at the first appointment and the second half at the final appointment.
  - b. Option 2: Pay the "patient portion" due at the time of service by cash, check, debit, American Express, Visa, MasterCard, Discover, or Care Credit.
6. **Unpaid balances:** Payment is due on the day of service unless other arrangements are made in writing. Any balance billed to the patient after the date of service is due within 30 days. Overdue accounts will be sent to collections and incur a \$75 collections fee.
7. **Insurance:** Insurance is a contract between the patient and the insurance company. The Faculty Dental Practice is not a party to this contract. If insurance estimates are received from your insurance company, the patient will be allowed to pay the estimated co-payment at the time of service. As a courtesy, the insurance company will be billed for the balance. If insurance does not pay within 90 days or if there is a balance after the insurance payment, the patient is responsible to pay the remaining balance due within 30 days of notification that insurance has not paid.
8. **Animals:** Animals/Pets are not allowed in the Hospital and Clinics, with the exception of those animals trained to assist a disabled person in one or more daily activities (Assistance Animal). An Assistance Animal which is not trained, well-cared for and well-behaved may be restricted or excluded from Hospital/Clinic facilities. An Assistance Animal is permitted only in areas where the presence or use of the animal does not jeopardize the health or safety of the Hospital/Clinic's patients or require a fundamental alteration of services.



**Patient Agreement:**

1. I understand that records and materials, including radiographic images pertinent to the patient's treatment, become the property of the Oregon Health & Science University, School of Dentistry. The School may utilize these records in photographic reports or scientific publications for advancement of dental teaching. If I want copies of my records, I agree to fill out the appropriate release form, pay the processing fee, and wait 1-3 weeks for the request to be fulfilled.
2. I agree to give at least 48 hours advance notice if I need to reschedule or cancel my appointment. If sufficient notice is not given, I agree to pay a \$50 "No Show" charge.
3. I understand that a responsible parent or guardian must accompany minor patients for all examinations and surgical appointments.
4. I understand that during the course of treatment, it may be determined that additional treatment may not be in my best interest or in the best interest of my dental provider, at which time I may be discontinued from continued care.
5. I consent to the acquisition, evaluation, and interpretation of necessary diagnostic information, including health questionnaire, extraoral examination, intraoral examination, ordered dental radiographs, consultations from other health care providers, and other diagnostic procedures as deemed beneficial to patient assessment and diagnosis. I understand I will be informed of a plan of treatment, including possible risks and alternatives prior to the beginning of dental care.
6. I understand that photographs may be taken while receiving dental services at OHSU for OHSU's purposes only (consistent with state and federal law). Pictures will be used solely for treatment, education, reimbursement, and/or certain administrative and business activities supporting the delivery of care at OHSU.
7. I understand that I may receive communication via phone, email, text messaging, or other methods.
8. I understand that a \$35.00 service fee will be charged for any payments made by check that is returned because of insufficient funds. I understand that if it becomes necessary to pursue collections of any amount owed, I agree to pay a minimum \$75.00 collection fee.
9. I understand that fees are listed on a standard fee schedule and correspond to the type of dental treatment deemed necessary by the supervising faculty. I understand that fees may be updated twice per year and that I will be responsible to pay current fees.
10. By signing below, I agree to accept responsibility of any unpaid balance after my insurance carrier has been billed. I understand that I am responsible for payment of all fees for treatment I receive, regardless of insurance coverage. I authorize release of any information relating to my dental claims and I hereby authorize payment of insurance benefits for my dependents and/or me to the Oregon Health and Science University School of Dentistry.





**The statement of Patient Rights and Responsibilities is as follows:**

Effective 9/17

The students, faculty, and staff of the School of Dentistry strive to provide high-quality dental care in a patient-friendly atmosphere.

**All of our patients are entitled to:**

- Continuous and complete treatment that meets professional standards of care
- A clear explanation of recommended and alternative treatment options, the option to refuse treatment, the risks of no care, and expected outcomes of various treatments
- Current information about their dental health care status and progress of care
- Advanced knowledge about the cost of treatment
- Treatment with respect, consideration, and confidentiality
- The right to ask questions anytime about their dental care
- Access to a patient advocate for assistance
- Informed consent before any procedure is performed
- Confidentiality regarding medical conditions, oral health, and patient records

**As an OHSU School of Dentistry patient you have a responsibility to:**

- Be thoughtful of other patients and visitors
- Refrain from using discriminatory, profane, derogatory, or threatening language or behavior
- Be considerate and respectful of those who are assigned to help you. Staff and providers will not be reassigned for reasons of race, ethnicity, creed, gender or other characteristics unrelated to their ability to provide service or care. Exceptions will be considered on a case-by-case basis.
- Provide accurate, honest and complete information about your medical and dental history that will help us care for you, including information about medications and drugs you have used, previous illnesses, injuries or medical and dental care you have received, and information about your current health status
- Participate in your oral health care decisions
- Ask questions when you do not understand
- Follow your oral health care provider's instructions once you have agreed to the recommended care
- Accept the consequences resulting from failure to follow the agreed upon treatment plan
- Be available for appointments depending on the student and clinic schedules
- Cancel appointments you are unable to keep at least 24 hours in advance
- Be financially responsible for all care received except for the financial or welfare assistance listed on the Patient Information Form
- Notify School of Dentistry business services of any change in your dental insurance or welfare coverage
- Share your concerns, and provide suggestions and compliments that will help us provide high-quality, compassionate care



By signing below:

- I acknowledge that I have been provided a copy of the OHSU Notice of Privacy Practices and Patient Rights and Responsibilities.
- I acknowledge that I have read, fully understand and agree to the OHSU Terms and Conditions of Service consent.
- I acknowledge that I have read and understood the FDP Patient Information and Agreement. I agree to abide with the rules and regulations of the School of Dentistry.
- I understand that I may request and be provided a copy of these forms.

**Patient Name:**

**Chart:**

**Date:**

**Signature of Patient (If Applicable):**