SOUTH PORTLAND SURGICAL CENTER
6370 SW Borland Road Suite 100
Tualatin, OR 97062
Phone: 503-218-1105

Welcome!

On behalf of the entire staff, we welcome you and look forward to your upcoming visit at South Portland Surgical Center. Our staff is dedicated to providing individualized, high quality medical care in a confidential, caring, and respectful environment.

We have enclosed the following documents for you to review, complete and bring with you to your appointment:

- South Portland Surgical Center Brochure
- Registration Form
- Financial/Billing Policy
- Patient Medication Reconciliation
- Deep Vein Thrombosis (DVT) Risk Assessment
- Pre-Anesthesia Questionnaire

Please help us better serve you and make your admission process as easy as possible by reading all the enclosed forms and completing all enclosed forms before you arrive at our facility. Please remember to complete the Patient Medication Reconciliation form in its entirety, including dose, frequency, date/time last taken, route and the purpose for use.

Financial/Billing Information: South Portland Surgical Center is in-network with most major insurance plans. You may be contacted by our team to review benefits and discuss financial responsibility prior to your procedure. If you have questions about your financial responsibilities, please call us and our financial coordinators will be happy to assist you.

For assistance with the doctor's fees please contact their office. For questions regarding the anesthesiologist fees please contact Oregon Anesthesiology Group (OAG) at 503-299-9906.

Pre-Op Screening Call: You will receive a call from a nurse at our facility prior to your appointment to review your medical history, medications and give preparation instructions for the procedure. We recommend having your registration forms completed prior to that call to expedite the process. If you have not received a call 24 hours prior to your procedure, please contact us.

Surgery Times: Surgery times are subject to change for a variety of reasons up to the day before surgery. In an effort to reduce confusion, we will call you the day before your surgery with a confirmed arrival time. If you have not received a call by 2pm, please call our scheduling team at 503-905-3708.

We hope you will find the care you receive at South Portland Surgical Center a pleasant experience. The staff are grateful to care for you or your family member and hope for a smooth and speedy recovery.

Sincerely,

The Physicians and Staff of South Portland Surgical Center

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REGISTRATION FORM

Last Name _____ First Name _____ MI _____

Address _____
(Street) (City) (State) (Zip)

Mailing Address _____
(City) (State) (Zip)

Cell Phone _____ Home Phone _____ Work Phone _____

Date of Birth _____ Email Address _____

Employer _____ Occupation _____

In case of emergency, contact:

Name _____ Relationship _____

Daytime Phone # _____ Cell Phone # _____

Responsible Party (if not patient):

Last Name _____ First Name _____ MI _____

Address _____
(Street) (City) (State) (Zip)

Home Phone _____ Cell Phone _____ Work Phone _____

Employer _____ Occupation _____

Medical Insurance Information (please fill out COMPLETELY):

Primary Insurance _____ ID# _____ Group # _____

Subscriber _____ Subscriber DOB _____

Relationship to patient _____ Employer _____

Secondary Insurance _____ ID# _____ Group # _____

Subscriber _____ Subscriber DOB _____

Relationship to patient _____ Employer _____

Is your procedure related to a workers compensation injury or motor vehicle accident? Y N

Workers Compensation / Motor Vehicle Accident / Third Party Liability / Lawsuit (please fill out COMPLETELY):

Insurance Company _____ Phone # _____

Claim# _____ Date of Accident/Injury _____

Adjuster Name _____ Phone # _____

Name of Attorney _____ Phone #_____ Fax #_____

Address of Attorney _____

SOUTH PORTLAND SURGICAL CENTER

Release of Information and Conditions of Admission

(patient initial by each consent)

Initials

_____ **Release of Information**

I hereby authorize SPSC, LLC to provide all the patient's recorded information included in the medical record to the patient's insurance company.

_____ **Transfer of Information**

I hereby consent to the release and transfer of records in the unlikely event it becomes medically necessary for transfer of patient to hospital while in the care of SPSC, LLC. I further consent to the release of the hospital discharge records to SPSC, LLC upon discharge from the hospital.

_____ **Authorized Personnel**

I hereby authorize personnel requested and approved by my surgeon and South Porland Surgical Center management to be in the operating room.

_____ **Authorized Imaging**

I hereby consent to the use of imaging during my procedure, if necessary. I consent to the images being taken during my procedure by my physician or a designee approved by my physician for the purpose of medical treatment. I consent that these images will become part of my medical record. Examples of imaging needed during surgery: Fluoroscopic imaging (X-ray), arthroscopic video and picture imaging and ultrasound imaging.

_____ **Assignment of Benefits**

I hereby authorize my Insurance company to make payment directly to South Portland Surgical Center, LLC for the medical and surgical benefits allowable and otherwise payable to me under the current insurance policy. I have received a copy of the Financial Agreement.

Oregon Anesthesiology Group

Oregon Anesthesiology Group, P.C.
Assignment of Benefits and Communications

South Portland Surgical Center contracts with Oregon Anesthesiology Group, P.C. to provide an anesthesiologist for your procedure. *Oregon Anesthesiology Group, P.C.* will send you a separate bill for these services.

Assignment of Benefits

For services rendered, I hereby assign to and authorize payment directly to *Oregon Anesthesiology Group, P.C.* of all benefits due to me under Medicare, Medicaid, or any insurance policy providing benefits for anesthesia professional services.

Communications

I acknowledge that South Portland Surgical Center and *Oregon Anesthesiology Group, P.C.* may contact me by phone or through any electronic communication methods linked to me, including mobile numbers. I understand they may leave voicemail, text, or email messages containing information permitted by law (including under debt collection laws) about services provided to me or any amounts I may owe.

_____ _____

Signature of Patient or Responsible Party Date

_____

Name of Patient or Responsible Party

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SOUTH PORTLAND SURGICAL CENTER

FINANCIAL / BILLING POLICY

Please read the following information carefully as it applies to your financial responsibility.

Thank you in advance for your cooperation.

Understanding Your Insurance

Your medical insurance policy is a contract between you and your insurance carrier and South Portland Surgical Center is not a party to that contract. As a result, your coverage and responsibilities are determined by your policy and you are responsible for understanding and following their procedures. On your behalf, the Center will submit all your claims to your primary, secondary and tertiary insurance providers.

It is your responsibility to provide us with sufficient, accurate and up-to-date insurance and mailing address information. If your insurance carrier does not submit payment, you are liable for your entire account balance. It is your responsibility to contact your insurance carrier with any questions and to respond to any inquiries from them in a timely manner regarding your condition or procedure.

The Cost of Your Procedure

Once we receive your scheduling and insurance information from your surgeon's office, South Portland Surgical Center will contact your insurance carrier and verify eligibility and medical coverage for services at an Ambulatory Surgery Center.

Co-Payments, Deductibles and Estimated Co-Insurance amounts are due on the day of your surgery. If there is any anticipated patient responsibility you may be contacted by a Financial Coordinator to discuss these estimated costs before your scheduled procedure. If you have any questions, please call the business office at 503-218-1105.

Please note: You may receive up to 5 separate bills associated with your surgery. These include the Facility Fee, Surgeons Fee, Anesthesiologist Fee, Pathology/Lab Fee and Durable Medical Equipment (DME) if applicable.

Payment Responsibility

After your insurance has been billed, you remain responsible for the full balance. You will receive a statement in the mail and payment is due in full within 30 days. For your convenience we accept Cash, Check, Cashier's Check, Money Order, Visa, Mastercard, Discover, American Express and CareCredit. (There will be an NSF Charge for any Returned Checks).

If you are not covered by medical insurance or choose not to utilize your medical insurance for your surgery, our Center's policy requires payment in full on the day of your procedure. Please contact the Business Office Manager regarding your potential out of pocket costs.

Collections

If balances are not paid in full within 90 days or payment arrangements have not been made with the Financial Coordinator, your account may be referred to a formal collection agency. By signing below, you understand you are solely responsible for all costs, including attorney fees incurred by an outside agency in the collection of the outstanding debt.

Minors

A parent or legal guardian must accompany a minor and consent to treatment, unless otherwise stipulated by law. Parents or legal guardians must comply with the terms of this billing policy. If the parents of a minor are separated/ divorced, the Center has the right to require legal documentation determining which parent is financially responsible for paying the child's medical expenses or responsibility for determining the child's medical care needs. The parent or guardian that accompanies the minor to an office visit will be held responsible for payment of services should any dispute over payment arise.

Pre-Authorization/Pre-Certifications

If your medical insurance plan requires you to have a prior authorization or pre-certification to be on file for a procedure, this should be obtained before your scheduled procedure. The Center makes every attempt to follow-up with your physician's office to see that the authorizations are obtained prior to the surgery; however, the authorization must be obtained by the performing physician.

IF WE DO NOT HAVE THE REQUIRED PRIOR AUTHORIZATION OR PRE-CERTIFICATION; YOU WILL BE FULLY RESPONSIBLE FOR PAYMENT OF SERVICES RENDERED AT THE CENTER.

I have read and acknowledged the Financial/Billing Policy of South Portland Surgical Center and agree to the policies and patient responsibilities.

_____
Patient or Authorized Representative

_____ _____
Print Patient Name Date

Example:

Please fill out this worksheet as much as possible. Below are examples of how your worksheet should look.

SOUTH PORTLAND
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PATIENT MEDICATION RECONCILIATION

Include OTC, Herbals and Dietary Supplements

Drug Name	Dose	Frequency	Date/Time Last Dose	Route	Purpose for Use
Atenolol	25 mg	daily	2/12/18 0500am	oral	Blood Pressure
Albuterol inhaler	2 puffs	as needed	2/10/18 1200pm	inhaler	asthma
Nicotine patch	21 mg	daily	2/12/18 0600am	topical	quit smoking
Ibuprofen	200mg	as needed	2/11/18 7pm	oral	pain
Multivitamin	1 tablet	daily	2/12/18 0900am	oral	health

Drug **Allergy:** Penicillin Reaction: Rash
Drug **Allergy:** _____ Reaction: _____
Drug **Allergy:** _____ Reaction: _____

Drug **Allergy:** _____ Reaction: _____
Drug **Allergy:** _____ Reaction: _____
Drug **Allergy:** _____ Reaction: _____

Patient Signature (or Responsible Party) Jane Doe

Ordered at Discharge

Drug Name	Dose	Frequency	Last Dose	Route	Purpose for Use

Sources of Information (check all applicable):

❑ Patient/Family recall

❑ Other (specify): _____

Date/Time initiated/Nurse _____

Post-op RN _____

❑ Patient may resume all medications with the exception of:

_____

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PATIENT MEDICATION RECONCILIATION

Include OTC, Herbals and Dietary Supplements

Drug Name	Dose	Frequency	Date/Time Last Dose	Route	Purpose for Use

Drug **Allergy:** _____ Reaction: _____ Drug **Allergy:** _____ Reaction: _____
Drug **Allergy:** _____ Reaction: _____ Drug **Allergy:** _____ Reaction: _____
Drug **Allergy:** _____ Reaction: _____ Drug **Allergy:** _____ Reaction: _____

Patient Signature (or Responsible Party)_____

Ordered at Discharge

Drug Name	Dose	Frequency	Last Dose	Route	Purpose for Use

Sources of Information (check all applicable):

❑ Patient/Family recall

❑ Other (specify): _____

Date/Time initiated/Nurse _____

Post-op RN _____

❑ Patient may resume all medications with the exception of:

_____

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DEEP VEIN THROMBOSIS (DVT) RISK ASSESSMENT

Please answer the following questions so we can best determine if you may be at risk for Deep Vein Thrombosis.

YES	NO		YES	NO	
☐	☐	Are you 60 years of age or older? (Y=2 N=1)	☐	☐	Are you immobile? (Move less than 100ft 3 times a day) (2)
☐	☐	Do you have a history of blood clots, blood disorders or pulmonary emblous? (3)	☐	☐	Do you have a history of a heart attack, congestive heart failure or atrial fib? (3)
☐	☐	Do you have a history of leg swelling, leg ulcers, or varicose veins? (1)	☐	☐	Have you had cancer/chemo? (past/present) (3)
☐	☐	Are you having lower extremity surgery? (5)	☐	☐	Are you currently pregnant or postpartum less than 1 month? (1)
☐	☐	Do you have inflammatory bowel disease? (Crohn's Disease,Colitis) (1)	☐	☐	Do you have a history of a stroke, paralysis, and/or MS? (5)
☐	☐	Are you taking birth control or on hormone replacement therapy? (1)	☐	☐	Do you have a bleeding or clotting disorder? (3)
☐	☐	Do you have a port-a-cath or central line in place? (1)	☐	☐	Are you a smoker, have lung disease or recent pneumonia? (2)
☐	☐	Are you overweight? (slightly, moderately, extremely) (1)	☐	☐	Do you have a splint/cast that prevents limb movement and have been wearing it for more than 30 days? (1)
☐	☐	Have you had a recent trauma?(Fall, car accident, broken bones or spinal cord injury) (5)			

_____ _____

Patient Signature Date

OFFICE USE ONLY

☐ ☐ Major Surgery, longer than 1 hour? (Y=2, N=1)

TOTAL DVT RISK FACTOR SCORE: _____

☐ LOW RISK:	0-1	(Risk Proximal DVT 0.4%)	Recommended: Early ambulation 3 x daily > 100ft
☐ MOD RISK:	2	(Risk Proximal DVT 2-4%)	Recommended: SCD
☐ HIGH RISK:	3-4	(Risk Proximal DVT 4-8%)	Recommended: SCD
☐ VERY HIGH RISK:	5+	(Risk Proximal DVT 9-20%)	Recommended: SCD

FALL RISK ASSESSMENT

RISK FACTORS:	LEVEL	SCORE
Recent falls (within the past 3 months)	Low	2
Frequent falls (3 or more)	Moderate	4
Visually impaired, hx of stroke	Moderate	4
Uses cane or crutches	Moderate	4
Uses a walker or wheelchair	Moderate	4
Hx of inability to stand alone, unsteady gait	Severe	8
(Antihistamines, antihypertensives, diuretics)	1-2 medicatic	2
(Antiseziure medication, sedatives, hypnotics)	1-2 medicatic	4

(Low Risk= 0-4 Mod Risk=5-8 High Risk=9+)

TOTAL SCORE:_____ PT RISK: _____

FALL RISK BRACELET PLACED ON PATIENT ☐YES ☐NO

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PRE-ANESTHESIA QUESTIONNAIRE

Please answer the following questions so we can best tailor your anesthetic to your specific needs. Most people tolerate anesthesia very well. There are risks associated with anesthesia which rarely cause permanent injury or death. We would be happy to answer any questions regarding your anesthetic options or risks.

Height _____ **Weight** _____ **lbs** _____ **Kg** **BP** _____ **HR** _____ **SAT** _____ **Temp** _____

Have you had:	**Circle Answer**	
Surgery or anesthesia before	Yes	No
List surgeries _____		
_____		
_____		
_____		
Bad reactions to anesthesia (for example severe sore throat, nausea, or difficult intubation)	Yes	No
Relative with bad reaction to anesthsia (for example, malignant hyperthermia)	Yes	No
High blood pressure	Yes	No
Heart problems (abnormal rhythm or EKG, chest pain)	Yes	No
Breathing problems (asthma, heavy snoring, sleep apnea emphysema, abnormal chest x-ray)	Yes	No
Recent or current infection (cold, flu, communicable disease)	Yes	No
Liver problems (jaundice, hepatitis)	Yes	No
Bleeding problems or blood clot	Yes	No
History of Anemia	Yes	No
Kidney problems	Yes	No
Stomach or intestinal problems (heartburn, reflux, ulcers, hiatal hernia)	Yes	No
Diabetes (If yes, Insulin ___ Diet ___ Oral agent ___)	Yes	No
Neurologic problems (seizure, stroke, numbness, weakness)	Yes	No
Neck or jaw problems	Yes	No
Back problems or chronic pain	Yes	No
Joint problems or artificial joints	Yes	No
Cancer or chemotherapy	Yes	No

Do you:	**Circle Answer**	
Take medications?	Yes	No
List: _____		
_____		
_____		
_____		
Have allergies or reactions to medicine, latex, tape, eggs or iodine?	Yes	No
List: _____		
_____		
_____		
_____		
Smoke? Packs per day_____ for_____ yrs.	Yes	No
Quit when? _____		
Drink alcohol (more than occasionally)	Yes	No
Use recreational drugs?	Yes	No
Have any implanted electronic device, such as a pacemaker?	Yes	No
Wear contact lenses?	Yes	No
Have artificial lens or eye?	Yes	No
Have trouble hearing?	Yes	No
Have loose / removable teeth?	Yes	No
Have objection to a blood transfusion even in life threatening situations?	Yes	No
Female: Are you pregnant or nursing?	Yes	No

When did you last eat or drink? _____ am/pm
(On day of surgery)

Primary physician is: _____

Other medical problems, illnesses or injuries? Explanation or comments:

_____

_____

_____

Patient Signature_____
(or responsible party)

Date _____ **Time** _____

Oregon Anesthesiology Group
Consent for Anesthesia Services

This form is informational and meant to provide you with specifics about possible anesthetic services and anesthetic outcomes for your upcoming procedure. Please read this form thoroughly and if you have any questions or concerns please bring them up during your pre-operative phone call or on the day of surgery with your OAG anesthesiologist. A similar form will be provided on the day of your procedure and will be signed by you and your anesthesiologist after an in-person consultation.

You, in consultation with your physician, have decided to undergo a procedure that will require anesthesia to make it safer for the procedure to be performed and to lessen the discomfort you would otherwise experience. An anesthesiologist will be there during your procedure to monitor you while they provide specific anesthesia services. The determination of what type(s) of anesthesia services and techniques are best for you depends on factors including your physical condition, the type of procedure you are undergoing, and the preferences of you and your physician.

Even though anesthesia has become remarkably safe, all forms of anesthesia involve some risks and no guarantees can be made that you will not suffer a side effect or complication from your anesthesia. Although rare, unexpected and severe complications can occur with all forms of anesthesia, including: infection; bleeding; drug or allergic reactions; nausea; awareness under anesthesia; injury to eyes, lips, and teeth; injury to the vocal cords; respiratory/breathing problems; nerve injury with loss of sensation or function; paralysis; stroke; damage to liver, kidney, or lungs; heart attack; brain damage and even death. These risks apply to all forms of anesthesia and additional or specific risks have been identified below as they may apply to a specific type of anesthesia.

Anesthesia may have additional risks during pregnancy. In early pregnancy anesthesia medications may alter the development of the unborn child. If an operation for another medical condition while pregnant is required, labor may start before it would have otherwise.

Sometimes an anesthetic technique that involves the use of local anesthetics, with or without sedation, may not succeed completely and therefore another technique may need to be used to keep you safe, including general anesthesia.

General Anesthesia	Expected Result Technique Risks	• Total unconscious state, possible placement of a tube into your airway/windpipe • Medication injected into the bloodstream, breathed into the lungs, or by other routes • Injury to mouth, teeth, or throat, hoarseness or throat pain, awareness under anesthesia, aspiration, pneumonia, nausea, vomiting, injury to blood vessels
Monitored Anesthesia Care (with sedation)	Expected Result Technique Risks	• Reduce anxiety and pain, partial or total amnesia • Medication injected into bloodstream, breathed into the lungs, or by other routes to produce a semi-conscious state • Depressed breathing, injury to blood vessels
Monitored Anesthesia Care (without sedation)	Expected Result Technique Risks	• Measurement of vital signs, Anesthesiologist availability for further intervention • None • Awareness, anxiety, discomfort
Nerve Block	Expected Result Technique Risks	• Temporary loss of feeling and/or movement of a specific area or limb • Medication injected near nerves providing loss of sensation to the area of operation • Persistent numbness or weakness, nerve injury, infection, residual pain, convulsions, injury to blood vessels, failed block
Spinal or Epidural	Expected Result Technique Risks	• Temporary decreased/loss of feeling or movement of the lower part of the body • Medication injected through a needle/catheter placed either directly into the spinal canal or immediately outside the spinal canal • Headache, backache, infection, persistent weakness/numbness, residual pain, injury to spinal cord, convulsions, injury to blood vessels, unconsciousness

I consent to the service(s) checked above. I also consent to the alternative types of anesthesia, if necessary, as deemed appropriate by the Anesthesiologist. I understand the importance of providing my health care providers with a complete medical history including medications both prescription and over the counter. I understand that I may have other health issues that increase my risk of complications under anesthesia. I understand that my use of herbal remedies, alcohol, marijuana, or any type of illegal drug may give rise to serious complications and must also be disclosed. I also understand that I should disclose any complications that arose from past anesthetics. I acknowledge that I have read this form or had it read to me, that I understand the risks, alternatives and expected results of the anesthesia services and that I have had the time and opportunity to ask questions and to consider my decisions.

SOUTH PORTLAND SURGICAL CENTER - 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.

This Notice applies to ("Center") and health professionals when they provide services at the Center. Under federal law, your health information (known as "PHI") is protected and confidential. PHI includes information about your symptoms, test results, diagnosis, treatment, and related medical information and payment, billing, and insurance information. Your PHI may be stored and disclosed electronically.

How We Use & Disclose Your PHI

Treatment: We will use and disclose your PHI for treatment purposes. For example, nurses, physicians, and other members of your treatment team use PHI to determine the most appropriate course of care. We may also disclose PHI to other health providers who participate in your care.

Payment: We will use and disclose PHI for payment purposes. For example, we may need to obtain authorization from your insurance company before providing treatment, determine whether you are enrolled or eligible for benefits and submit bills to your health plan.

Health Care Operations: We will use and disclose your PHI to conduct our standard internal operations, including administration of records, credentialing, evaluation of the quality of treatment, arranging for legal services and assessing the care and outcomes of your case and others like it.

The Center and professionals covered by this Notice will share PHI with each other as permitted by law for treatment, for payment, and for the Center's health care operations.

Other Uses and Disclosures We May Make

Family/Friends/Disasters: We may disclose limited PHI to family members or friends who are helping with your care or payment for your care and to those assisting in disaster relief efforts. For example, following a procedure, we will disclose your discharge instructions and PHI related to your care to the individual who is driving you home or who is otherwise assisting in your post-procedure care.

Required by Law: We may disclose your PHI as required by law , such as to report gunshot wounds, suspected abuse or neglect, or similar injuries and events. For example, we may disclose your PHI to the U.S. Department of Health and Human Services if it requests PHI to determine that we are complying with federal law.

Research: We may use or disclose PHI for approved medical research.

Public health activities: We may disclose vital statistics, disease information, information related to recalls of dangerous products, and similar information to public health authorities.

Health oversight: We may disclose PHI to assist in investigations and audits, eligibility for government programs, and similar activities.

Judicial and administrative proceedings: We may disclose PHI in response to an appropriate subpoena, discovery request or court order.

Law enforcement purposes: We may disclose PHI to law enforcement officials as permitted by law, such as to report a crime on our premises.

Deaths: We may disclose PHI regarding deaths to coroners, medical examiners, funeral directors, and organ donation agencies.

Serious threat to health or safety: We may use and disclose PHI when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Military and special government functions: If you are a member of the armed forces, we may release PHI as required by military command authorities. We may also disclose PHI to correctional institutions or for national security purposes.

Workers compensation: We may release PHI for workers compensation or similar programs providing benefits for work-related injuries or illness.

Business associates: We may disclose PHI to business associates (individuals or entities that perform functions on our behalf) provided they agree to safeguard the information.

De-identification. We may use and disclose your PHI to create information that is de-identified. In other words, we may remove identifiers in order to create information that is no longer individually identifiable as defined by law. We may also remove most PHI that identifies you from a set of data and use and disclose this data set for research, public health and health care operations, provided the recipients of the data set agree to keep it confidential.

Health information exchanges. We may participate in one or more health information exchanges ("HIEs") and with your consent may electronically share your PHI for treatment and other permitted purposes with other HIE participants. HIEs allow your providers to efficiently access and use your PHI for treatment and other lawful purposes unless you opt out.

In any other case, we will ask for your written authorization before using or disclosing your PHI. If you sign an authorization, you can later revoke that authorization to stop any future uses and disclosures by contacting the Contact Person listed below. Subject to limited exceptions, we will not use or disclose psychotherapy notes, use or disclose your PHI for marketing purposes or sell your PHI, unless you have signed an authorization.

If we receive records from substance use disorder treatment programs subject to federal privacy rules (42 CFR Part 2) such records or testimony about their content cannot be used or disclosed in civil, criminal, administrative, or legislative proceedings against the individual unless based on written consent or a court order entered after notice and an opportunity to be heard is provided to the individual or us, as provided by 42 CFR Part 2. A court order authorizing use or disclosure must be accompanied by a subpoena or other legal requirement compelling disclosure before the requested substance use disorder record is used or disclosed.

We may use Artificial Intelligence or (AI) tools, for purposes described in this Notice and as permitted by the HIPAA Rules. For example, we may use tools that record your interactions with our providers and staff to assist with drafting notes or scheduling appointments.

Individual Rights

You have the following rights with regard to your PHI. Please contact the Contact Person listed below to obtain the appropriate form for exercising these rights. If you have given another individual a medical power of attorney, if another individual is appointed as your legal guardian or is authorized by law to make healthcare decisions for you (known as a "personal representative"), that individual may exercise any of the rights listed below on your behalf.

□ You may request restrictions on certain uses and disclosures. We are not required to agree to a requested restriction, except for requests to limit disclosures to your health plan for purposes of payment or health care operations when you have paid in full, out-of-pocket for the item or service covered by the request and when the uses or disclosures are not required by law.

□ You may ask us to communicate with you confidentially by, for example, sending notices to a special address or not using postcards to remind you of appointments.

□ You have the right to look at or get a copy of your PHI. There may be a reasonable cost-based charge for copies.

□ You have the right to request that we amend your PHI.

□ You may request a list of disclosures of PHI about you except for disclosures made with your authorization and other exceptions.

□ You have the right to obtain a paper copy of the current version of this Notice upon request, even if you have previously agreed to receive it electronically.

Our Legal Duties/Changes to this Notice

We are required by law to protect and maintain the privacy of your PHI, to provide this Notice about our legal duties and privacy practices regarding PHI, and to abide by the terms of the Notice currently in effect. We are required to notify affected individuals in the event of a breach involving unsecured PHI.

We may change this Notice at any time and make the new terms effective for all PHI we hold. The effective date of this Notice is listed at the bottom of the page. If we change our Notice, we will post the new Notice in the waiting area. For more information about our privacy practices, contact the Contact Person listed below.

Complaints/Contact Person

If you are concerned that we have violated your privacy rights, you may contact the Contact Person listed below. You also complain to the U.S. Department of Health and Human Services. The Contact Person listed below will provide you with the appropriate address upon request. You will not be penalized in any way for filing a complaint. If you have any questions, requests, or complaints, please contact:

Center Privacy Officer (503-218-1105)

INFORMATIONAL PURPOSES ONLY - ACTUAL NOTICE TO BE SIGNED DAY OF SURGERY