The Birthplace at Summerlin Hospital
A Member of The Valley Health System

Summerlin Birthplace Pre-Registration Packet

Welcome to the Summerlin Birthplace! We are excited you have chosen us to care for your growing family. Please pre-register with our hospital by following the steps below.

Instructions

- Please sign and date ALL forms included in this packet
- Submit completed forms along with insurance card(s) and photo ID to **SummerlinHospitalRegistration@UHSINC.com**

  Please Note: all images and documents must be uploaded or scanned into a PDF format. We cannot accept other file formats/photos of documents.
- Once the admitting team has completed your pre-registration, you will receive a confirmation number via email.

In-person registration is also available 24-hours a day by visiting our Admitting Department, located across from the Summerlin Emergency Department. *Please be sure to bring your insurance card(s) and photo ID. Questions? Call 702-233-7070.*

Interested in childbirth preparation classes or taking a tour of The Summerlin Birthplace?
Please visit: SummerlinHospital.com/services/maternity

The Valley Health System®

Centennial Hills Hospital • Henderson Hospital
Spring Valley Hospital • Summerlin Hospital • Valley Hospital
Valley Health Specialty Hospital *(An extension of Spring Valley Hospital)*
West Henderson Hospital

Summerlin Hospital

Congratulations on Your New Baby!

A new baby means you'll need to fill out many important forms. One of the most important is adding your baby to your health insurance plan. When you add baby to your plan, your insurance will start to pay for some of your baby's medical care. Here are some steps to help you.

When to Start

The sooner you get your baby added, the better! If you get healthcare insurance from your employer, most require you to add your baby to your plan within the first 30 days after birth. If you get healthcare insurance from the government (state or federal), they require you to add your baby within the first 60 days after birth.

How to Add Your Baby

Start by calling the number on your insurance card or by calling your employer's Human Resources Department. They can tell you what information they need from you.

Our Birth Registrar will help you fill out the Mother's Worksheet for Child's Birth Form. It includes these two documents:

- **Birth Certificate**
- **Social Security Number Form**

Note: If you have any questions or didn't receive these documents while in the hospital, please call the UHS Birth Registrar at: 702-233-7582

Finding a Doctor for Your Baby

The provider who cares for your baby during your hospital stay may only see newborns while they are in the hospital. Before you go home, you'll need to find a pediatrician (a doctor who cares for babies and children). Follow-up visits come quickly after birth (from two days to two weeks after you go home) so it's good to choose your baby's doctor right away.

To stay within the Valley Health System, call 702-388-4888 or visit https://doctors.valleyhealthsystemlv.com/ to find a VHS pediatrician who is right for you. Once you choose, please make an appointment.

If you do not have access to insurance, please call UHS's Financial Assistance partner, FirstSource: 702-233-7074 *or* 702-233-7076 to set up an appointment.

Conditions of Admission/Registration
Treatment Authorization and Financial Responsibility

As the individual who will be receiving services at Summerlin Hospital Medical Center LLC d/b/a Summerlin Hospital Medical Center (the "Hospital"), or the parent or guardian of the individual listed below as the patient, I agree to the following terms and conditions of this Conditions of Admission/Registration Treatment Authorization and Financial Responsibility Agreement (the " Agreement"). As applicable, I further agree that the terms and conditions of this Agreement apply to any newborn infant(s) I deliver while I am a patient in the Hospital.

1. **CONSENT TO HOSPITAL PROCEDURES:** I consent to the medical and surgical procedures which may be performed during this hospitalization or on an outpatient basis, including emergency treatment or services. These services and procedures may include but are not limited to laboratory tests, x-ray examination, newborn hearing screening, medical or surgical treatment or procedures, anesthesia, or Hospital services rendered under the general and special instructions of a physician. This general consent does not apply to any procedures which require informed consent.

2. **RELEASE OF INFORMATION:** I authorize the Hospital, physicians, and other licensed providers furnishing these services to disclose my Protected Health Information (" PHI") as that term is defined by the federal law referred to as "HIPAA" for purposes of treatment, payment and health care operations to third parties including but not limited to insurance carriers, health plans (including government health programs such as Medicare and Medicaid), or workman's compensation carriers that may be responsible for payment of the services (" Third Party Payors"). The PHI disclosed may include information about my treatment, medical care, medical history, billing information, and other information received or acquired by the Hospital and maintained in any form, including written, oral or electronically maintained information.

   Upon inquiry the Hospital will describe my condition to callers or the public using one of the following words; undetermined, good, fair, serious, or critical. If I do not want this information released I may make a written request for information about my condition to be withheld. I understand I can request a separate form to make this change.

3. **PROVIDERS NOT HOSPITAL EMPLOYEES:** I understand that the physicians furnishing services to me including Hospital-based physicians such as radiologists, pathologists, emergency department physicians, and anesthesiologists (" Hospital-Based Physicians") may be independent contractors and as such, are not employees or agents of the Hospital.

4. **HOSPITAL, PHYSICIAN, AND PRACTITIONER BILLING:** I understand that each physician, medical group, or other practitioner who provides professional services to me while I am in the Hospital, including Hospital-Based Physicians, will bill and collect for their professional services separate and apart from the Hospital. For purposes of assignment of benefits and agreement to pay for services, this Agreement applies to services rendered by the physicians and practitioners as well as the Hospital. I also understand I have the right to request an explanation of the Hospital billing process and a list of the Hospital's charges for any services I might receive.

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UHS-9018
Rev. 10/2025

Patient Identification

DOB:
MRN:

SX:

5. **MEDICAID MANAGED CARE PLANS:** I assign any and all insurance benefits payable to me to the Hospital. I understand that I am responsible for payment for services rendered at the Hospital including excluded services from my insurance either because the plan deems such services not medically necessary, or for any other reason including pre-certification requirements, second opinions or pre-existing conditions. Should the account be referred to any attorney or collection agency for collection, I understand that I will be responsible for attorney or collection expenses. I give permission to my insurance provider(s), including Medicare and Medicaid, to directly pay this Hospital for my care instead of paying me. I understand that I am responsible for any health insurance deductibles and co-insurance and non-covered services. I further assign my rights to this Hospital, and hereby appoint this Hospital as my personal representative, to (i) submit claims for payment for services and treatment rendered to me to payors, including but not limited to Medicare and Medicaid, and further assign my rights to/for payment for services and treatment rendered to me, and (ii) appeal from any and all denials of coverage, without limitation, to the Hospital.

6. **HEALTH PLANS (HMO&PPO):** I understand I am responsible for providing the Hospital with my primary care physician's name and practice information. I understand that some Health Plans may not fully cover services if the Hospital and/or its affiliated physicians and practitioners are not participating providers in my Health Plan, which can result in increased costs for me. I also understand that some Health Plans may review emergency room visits and services after the services are furnished to determine if the visit qualified as an emergency. If the Health Plan concludes the visit was not an emergency, I may be responsible for all physician and Hospital charges associated with the visit and I agree to pay for such services in accordance with the terms of this Agreement.

7. **Your Rights and Protections Against Surprise Medical Bills:** When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or "balance billing". Under Federal and Nevada law, you are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles) that you would pay if the provider or facility was in-network, unless you are given adequate notice and provide consent to be billed out-of-network rates for non-emergent services. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. Out-of-network providers can't "balance bill" you for the difference between what your plan agreed to pay and the full amount charged for a service, and they may not ask you to give up your protections not to be balance billed.

8. **ASSIGNMENT OF BENEFITS:** I authorize direct payment to the Hospital, Hospital-Based Physicians and other practitioners involved in my care and treatment of all insurance benefits payable to me or on my behalf for services provided during this hospitalization, or for outpatient services or emergency services if applicable. I understand that I am financially responsible for any non-covered changes.

9. **FINANCIAL AGREEMENT:** I agree, whether signing as a parent, guarantor, agent or the patient, that in consideration of the services provided by the Hospital, I will promptly pay all Hospital bills in accordance with the Hospital's standard charges for such services, and, if applicable, the Hospital's charity care and discount payment policies, as well as in accordance with applicable and state and federal law. Should my account be referred to an

attorney or collection agency for collection, I will pay actual attorney's fees and collection expenses. I understand that all delinquent accounts may be charged interest at the legal rate.

I certify that the information I have provided is true and accurate to the best of my knowledge. I understand that the information I submit is subject to verification, including credit agency scoring, and subject to review by federal and/or state agencies and others as required. I authorize my employer to release proof of my income to the Hospital if requested. I understand that if any information I have given proves to be untrue, the Hospital may re-evaluate my financial status and take whatever action becomes appropriate.

10. **CHARITY CARE AND DISCOUNTED PAYMENTS:** If you do not have health insurance, you may qualify for financial assistance. If you think you may be eligible for financial assistance to help with payment of your Hospital bills, please call:

    Hospital Financial Counselor: (702) 233-7668 or

    Central Billing Office: (702) 894-5700

11. **AUTHORIZATION FOR RECEIVING MESSAGES AND AUTOMATED CALLS:** By providing my telephone number and/or email address during the registration process, or at any time in the future, I represent that I am the user of the telephone number and email address provided, and I expressly authorize the Hospital, and its agents and/or other parties authorized to act on its behalf, including, but not limited to, debt collectors, or others calling regarding my hospital visit to contact me and leave voice messages, send text messages, or send electronic communications to me at the provided telephone numbers or email addresses using various means, including artificial or prerecorded voice or automatic telephone dialing systems. I understand that these calls, voice messages, text messages, and email communications will be related to my care and treatment, including my hospital visit, my account, my eligibility for government programs, my eligibility for charity care programs, or amounts I may owe.

    I understand that standard call and text charges may apply, and the frequency of the calls and texts may vary. I further understand that I may opt-out of receiving text messages, artificial or prerecorded voice messages, or autodialed calls at any time by writing the Hospital at 657 Town Center Drive, Las Vegas, NV 89144, calling (702) 233-7000, or responding "STOP" to text messages, or that I may limit communications to a specific telephone number or email address by requesting that only a designated number or email address be used for these purposes.

12. **MEDICARE CERTIFICATION, AUTHORIZATION TO RELEASE PAYMENT INFORMATION AND PAYMENT REQUEST:** I certify that any information given by me in applying for payment under title XVIII of the Social Security Act (Medicare) is correct. If applicable, I authorize the Hospital, Hospital Based Physicians or any other health care providers who have medical or other information about me to release any information needed for this or a related Medicare claim to the Social Security Administration or its intermediaries or carriers. I request that payment of authorized benefits be made on my behalf.

13. **GENERAL DUTY NURSING:** I understand that the Hospital provides only general duty nursing care unless my physician orders more intensive nursing care. If my condition requires a special duty nurse, I understand that it must be arranged by me or my legal representative. The Hospital is not responsible for providing or paying for such special duty nurses.

14. **PERSONAL VALUABLES:** I understand that the Hospital maintains a safe for the safekeeping of money and other valuables, and that the Hospital is not liable for the loss of my valuables unless they are deposited with the Hospital for safekeeping. I understand that I am responsible for all my personal effects not deposited in the safe, including, but not limited to, personal grooming articles, jewelry, cellular phones, tablets, other electronic devices, clothing, documents, medications, eye glasses, hearing aids, dentures and other prosthetic devices.

15. **ASSUMPTION OF RISK:** If I leave the Hospital before being released or discharged by my physician, or if I fail to follow instructions given to me by my physician or other healthcare professionals, I agree to assume all responsibility for any injury or damages suffered, and further agree to release and hold the physicians, their agents, the Hospital, it's employee's or agents harmless from any claims, demands or suits for damages from any complications associated with such actions.

16. **PHOTOGRAPHY, VIDEO, AND AUDIO FOR PURPOSES OF DIAGNOSIS, TREATMENT OR EDUCATIONAL TRAINING:** I understand that pictures or video may be taken of my medical/surgical condition or treatment. I understand that the pictures or video may be used for the purpose of my diagnosis, treatment or for educational training conducted by the Hospital. If pictures are taken for diagnosis and treatment purposes, they will be maintained as part of my medical record. Physicians or licensed providers may make audio recordings of my diagnosis and treatment sessions for notetaking, charting, and other treatment related purposes. I consent to the creation and use of these audio recordings of my diagnosis and treatment sessions for these purposes.

17. **NON SMOKING CAMPUS:** I understand that smoking is not permitted on the campus of the Hospital, except in designated areas and I agree to comply accordingly.

18. **COMPLAINTS:** I understand that I have the right to express any concerns I may have about my care and treatment to Hospital management.

19. **DATA COMPILATION FOR RESEARCH:** The undersigned hereby authorizes the Hospital to use a patient's data (or human tissues) by categories to be available for potential use in research studies. If a patient's information is to be used for a research study, the patient may be asked to sign an additional authorization at that time.

20. **USE OF ARTIFICIAL INTELLIGENCE SYSTEMS:** To better aid in the provision of care, the Hospital, physicians, and other licensed providers may utilize artificial intelligence systems and tools in connection with their provision of health care treatment and/or related services that I may receive at the Hospital. I have received notice that such artificial intelligence systems and tools may be used during my receipt of treatment and services at the Hospital, and that I may interact with artificial intelligence systems and tools during my stay at the

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Patient Identification

DOB:
MRN:

SX:

Hospital. I consent to the use of such artificial intelligence tools and systems for these purposes.

By signing below, I acknowledge that I have received a copy of the "Patient's Bill of Rights" and "Patient Responsibilities"; I have also carefully read and fully understand this Agreement and received a copy for my records if one was requested, I accept its terms, and am authorized to execute the Agreement. The Hospital's provision of services to you is not contingent upon your signing this consent form.

PATIENT/PARENT/GUARDIAN SIGNATURE	DATE / TIME
RELATIONSHIP IF NOT PATIENT SIGNATURE	DATE / TIME
REASON PATIENT DID NOT SIGN	DATE / TIME

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PATIENT RIGHTS AND RESPONSIBILITIES ADDENDUM

You have a right to consent to receive the visitors whom you designate, including, but not limited to a spouse, a domestic partner (including a same-sex domestic partner), another family member, or a friend, and you shall have the right to withdraw or deny such consent at any time.

Before you are furnished patient care, if possible, you also have the right to designate a Support Person who can exercise your visitation rights in the event you are incapacitated or otherwise unable to do so. See below.

Patient Visitation rights shall not be restricted, limited or otherwise denied by the hospital on the basis of race, color, national origin, religion, sex, gender identity, sexual orientation, or disability.

All visitors shall enjoy full and equal privileges consistent with your preferences. The Hospital may impose clinically appropriate limitations on patient visitation when visitation would interfere with your care whether the reason for limiting or restriction visitation is infection control, disruptive behavior of visitors, or you or your roommates need for rest or privacy.

Patient Visitation Rights:
In the event I am incapacitated or otherwise unable to exercise my patient visitation rights, I designate the following individual as my Support Person:

_____

Support Person Name (Print)

OR

I decline to designate a Support Person under patient visitation rights at this time. I understand I can change this decision at any time by notifying nursing or registration staff.

_____ _____/_____

Patient Signature Date Time

☐ Unable to assign a designee due to medical condition.

_____ _____/_____

Witness Signature Date Time

Summerlin Hospital Medical Center
Admitting Department

Date of Service/ Fecha: _____

Patient Account/ Numero de Cuenta: See Below

This is to confirm that I have had returned to me, all insurance cards and/or ID, by the Patient Service Representative during my registration/admission on the above stated date.

Por medio de la presente confirmo que se me han regresado, todas las tarjetas de seguro medico y/o de identificacion de parte de el representante al paciente durante mi registro/internacion en la fecha arriba indicada.

_____ _____

Signature- Patient/ Representative/ Legal Guardian — Date
Firma del Paciente/ Representante/ Guardian Legal — Fecha

_____ _____

Patient Service Representative — Date

_____ Patient Unable to sign
PSR initials

Attach Patient Label

CommonWell Health Alliance
Health Information Exchange
Opt-In/Opt-Out Request Form

The purpose of this Notice is to advise you that Valley Hospital Medical Center participates in the CommonWell Health Alliance Health Information Exchange. CommonWell is a nationwide data sharing network that facilitates the electronic exchange of individual protected healthcare information (PHI) among CommonWell participating health care providers in order to coordinate effective healthcare services.

CommonWell Health Alliance Health Information Exchange participation is voluntary. You have the right to opt-in or opt-out of this health information data exchange

- If you opt-in now, you may opt out at a later date. PHI that was previously shared will not be withdrawn from the provider(s) who already received it, but no new PHI will be shared via the Exchange.
- If you opt-out now, you may opt-in at a later date. PHI collected during the opt-out period will be visible to participating health care providers upon opt in.
- If you choose to opt-out, each of your health care providers will need to request a copy of your records via other means.
- If you opt-out, you will not be denied treatment or otherwise penalized.

OPT IN: I wish to have my personal health information shared via the CommonWell Health Alliance Health Information Exchange. I understand that my past and present health information will be visible to my health care providers.

Patient/Authorized Representative	**Date/Time**
Relationship if not Patient	**Date/Time**
Witness	**Date/Time**

OPT OUT: I do not wish to have my personal health information shared via the CommonWell Health Alliance Health Information Exchange, and hereby exercise my right to opt out of such sharing.

Patient/Authorized Representative	**Date/Time**
Relationship if not Patient	**Date/Time**
Witness	**Date/Time**

HealtHIE NEVADA

For Internal Use Only: MRN_____

Patient Consent Form for Electronic Exchange of Individual Health Information

Please read through the consent form and provide the following information: (Please Print)

CL0005

DOB: SX:
MRN:

☐ **Nevada Medicaid Patients Please Read:** Nevada law mandates that "a person who is a recipient of Medicaid or insurance pursuant to the Children's Health Insurance Program may not opt out of having his or her individually identifiable health information disclosed electronically" (NRS 439.539). When a patient is no longer a Medicaid recipient, it is the patient's responsibility to change their consent choice, if they choose to do so. Please sign below to indicate your acknowledgement.

Consent Choices: (CHECK ONE) Nevada Medicaid Patients are exempt from making a selection.
Your choice to give or to deny consent may not be the basis for denial of health services.

☐ **I CONSENT** for all HIE participants to access **ALL** of my electronic health information (including sensitive information) in connection with providing me any health care services, including emergency care.

☐ **I CONSENT ONLY IN CASE OF AN EMERGENCY** for all HIE participants to access **ALL** of my electronic health information (including sensitive information) **ONLY** in the event of a medical emergency.

☐ **I DO NOT CONSENT** for any HIE participants to access **ANY** of my electronic health information **EVEN** in the event of a medical emergency.

_____ _____
Signature of patient or authorized representative Date Time

If I sign this form as the Patient's Authorized Representative, I understand that all references in this form to "I", "me" or "my" refer to the Patient.

_____ _____ _____
Name of Authorized Representative (Printed) Relationship Date Time

_____
Address of authorized representative signing this form (please print):

_____
Phone number of authorized representative

FOR INTERNAL USE ONLY
Name of Organization:_____ Name of Witness:_____
As a witness to this Consent, I attest that the above signer is personally known to me or has established his/her identity with me by satisfactory photo ID, insurance card, or other evidence of identity customarily relied upon in health care.

RECEIPT OF NOTICE OF PRIVACY PRACTICES FORM

Version Date: 2/16/2026

Patient Name:
Account Number:
Medical Record Number:
Date of Service:

I acknowledge that I have received the Hospital's Notice of Privacy Practices.

Signature	Date/Time

Patient's Authorized Representative	Relationship to Patient	Date/Time

Witness Signature	Date/Time

NOTICE OF PRIVACY PRACTICES

This Notice describes how health information about you may be used and disclosed, your rights with respect to your health information, including how you can get access to your health information, and how to file a complaint concerning a violation of the privacy or security of your health information or of your rights concerning your information.

You have a right to a copy of this Notice (in paper or electronic form) and to discuss it with our Privacy Officer by calling 1-800-852-3449 or emailing privacy@uhsinc.com if you have any questions.

Please review this Notice carefully.

OUR COMMITMENT TO PROTECT YOUR HEALTH INFORMATION

As part of our promise to provide you with superior quality health care, we strive to protect the privacy and security of your health information. Your health information consists of any information that identifies you and the treatment you receive at our Facility, as well as information related to any payments we receive for your treatment. Your health information may be in various formats, including paper and electronic records, and can include photographs, videos, and other electronic transmissions or recordings that are created as part of your treatment.

This Notice of Privacy Practices (Notice) provides you with information on how federal and state laws require or permit us to use or disclose your health information. When federal and state privacy laws are different, we will follow the law that is more protective of your health information or provides you with greater access to your information. For example, while federal law protects all health information, there are specific federal laws and regulations that require additional protections for a patient's health information related to their diagnosis, treatment, or referral for treatment in health care programs that treat patients for substance use disorders. In this Notice, we will explain how federal law protects your health information and also explain when additional protections for substance use disorder health information may apply.

OUR COMPLIANCE WITH THE TERMS OF THIS NOTICE

The privacy practices described in this Notice will be followed by our Facility's workforce members, which includes our employees, employed health care providers, volunteers, health care students, and residents. The privacy practices described in this Notice may also be followed by health care providers who are members of our Medical Staff if they have opted to abide by its terms. If a Medical Staff member has opted not to abide by the terms of this Notice, they will provide you with a copy of their own Notice of Privacy Practices.

We reserve the right to change our privacy practices from time to time as permitted or required by law. These changes may impact health information, including substance use disorder health information, that we created or received prior to the change in our practice. If we make a material change to our privacy practices, we will revise this Notice and provide you with a copy of our revised Notice at your next appointment or admission (or as soon as practicable thereafter) at our Facility. You may also find our most current Notice posted within our Facility, on our website, and you have the right to ask for a paper or electronic copy of the Notice at any time. Except when required by law, any material changes to our privacy practices will not be implemented prior to the effective date of the revised Notice.

The effective date of this Notice is February 16, 2026.

HOW YOUR HEALTH INFORMATION MAY BE USED OR DISCLOSED

Federal law allows us to use your health information within our Facility and disclose your health information to others outside of our Facility for various purposes that are described in this Notice. Some uses and disclosures are required, some are permissible, and other uses and disclosures can only be made with your permission.

- **Required Disclosures**: Some uses or disclosures of your health information are required by law. When a use or disclosure of your health information is required by law, we will comply with the law. We do not need your permission to use or disclose your health information if the use or disclosure of your health information is required by law.
- **Permitted Disclosures**: Some uses or disclosures of your health information are permitted by law, meaning that we are not required to use or disclose your information for the permitted purpose, but we are permitted to use or disclose your health information for that purpose if we need to. We do not need your permission to use or disclose your health information if the use or disclosure is permitted by law.
- **Authorized Only Disclosures**: Some uses or disclosures of your health information are only allowed if we have received your permission to use or disclose your health information for that purpose. If your permission is required, we must obtain a written authorization from you or your personal representative before we can use or disclose your health information for that purpose.

REQUIRED DISCLOSURES

We will disclose your health information, including substance use disorder health information, when required to do so by federal or state law. For example, we may be required to report instances of abuse, neglect, or domestic violence, or that a patient has a certain transmissible disease.

PERMITTED DISCLOSURES

In most cases, our use and disclosure of your health information (not including your substance use disorder health information unless specifically indicated below) is permitted by law and your permission is not required. The law permits us to use or disclose your health information for the following purposes:

•**Treatment.** We will use and disclose your health information in order to provide you with treatment at our Facility. Our doctors, nurses, therapists, technicians, nursing or medical students, and support staff need your health information to take care of you. For example, if we test your blood in our laboratory, our lab technician will need to share the test results with your doctor in order for your doctor to make a diagnosis. We may also need to disclose your information to doctors or others who work outside our Facility. For example, your doctor may need to share your health information with a home health care nurse so that your care can continue once you leave our Facility, or we may need to share your health information with your pharmacy so that you can receive the medications that have been prescribed to you. If we have received your substance use disorder health information from your substance use disorder health care provider, we may further use and disclose this information for treatment purposes without your permission as long as our use and disclosure of your information is in compliance with other federal and state healthcare privacy laws, except for uses and disclosures for civil, criminal, administrative, and legislative proceedings against you. If we are your substance use disorder health care provider, we need your permission before we can use and disclose your substance use disorder health information for treatment purposes as described below.

•**Payment.** We may need to use and disclose your health information so that the treatment you received at our Facility can be paid for by your health insurer or other third party. For example, your health information may be needed by your insurer in order for them to determine whether the treatment you need is covered by your health plan or how much your out-of-pocket costs may be. We may also need to disclose your health information to a collection agency if a bill for treatment you received at our Facility has not been paid. If we have received your

substance use disorder health information from your substance use disorder health care provider, we may further use and disclose this information for payment purposes without your permission as long as our use and disclosure of your information is in compliance with other federal and state healthcare privacy laws, except for uses and disclosures for civil, criminal, administrative, and legislative proceedings against you. If we are your substance use disorder health care provider, we need your permission before we can use and disclose your substance use disorder health information for payment purposes as described below.

•**Healthcare Operations.** We need to use and disclose your health information for our healthcare operations. These types of uses and disclosures allow us to operate our business and provide you with superior quality care. For example, we may use and disclose your health information to review the effectiveness of your treatment. We may also use your health information to evaluate the performance of our workforce members and to provide them with education on pertinent medical issues. If we have received your substance use disorder health information from your substance use disorder health care provider, we may further use and disclose this information for healthcare operations purposes without your permission as long as our use and disclosure of your information is in compliance with other federal and state healthcare privacy laws, except for uses and disclosures for civil, criminal, administrative, and legislative proceedings against you. If we are your substance use disorder health care provider, we need your permission before we can use and disclose your substance use disorder health information for health care operations purposes as described below.

•**Medical Emergencies.** We may use and, when necessary, disclose your health information, including substance use disorder health information, to other medical personnel to the extent necessary to treat you in a medical emergency situation. If you have not previously given us permission to disclose your substance use disorder health information to the medical personnel treating you during the emergency, we will request that they do not further use or disclose that information.

•**Individuals Involved in Your Treatment or Payment for Your Treatment.** Unless you tell us otherwise, or a specific federal or state law prohibits such a disclosure, we may disclose your health information to a friend or family member who is involved in your treatment or is helping with the payment for your treatment.

•**Business Associates/Qualified Service Organizations.** We may disclose your health information, including substance use disorder health information, to various vendors and contractors who need that information to perform services on our behalf related to your treatment, payment for treatment, and our health care operations. These vendors and contractors are generally known as Business Associates, or if they have access to substance use disorder health information, are generally known as Qualified Service Organizations. Business Associates and Qualified Service Organizations are required to protect the privacy and security of your health information and substance use disorder health information by law and pursuant to a contract they have entered into with us.

•**To Contact You About Your Medical Care.** We may use and disclose your health information to contact you. For example, we may call you to remind you about an upcoming appointment or provide you with information related to tests or treatments you received at our Facility, or to let you know about treatment alternatives and other health related benefits and services we can offer you. We may contact you by mail, telephone, email, or text message. These contacts will be made in accordance with the law, which may require your consent prior to contacting you.

•**Patient Directories.** Our Facility may include limited health information about you for our patient directory, such as your name, location within our Facility, and your general condition (for example: good, fair, serious, critical, undetermined). We give this information only to people who ask for you by your name. These disclosures allow your family and friends, or others, such as florists who may have deliveries for you, to know where to find you in the hospital and how you are doing. If you do not want your information in the patient directory, you can notify our admissions department and we will not release any of this information. We do not release this

information if you are being treated at our Facility for a substance use disorder or state law would prohibit the disclosure.

•**Health Information Exchange.** We may participate in one or more health information exchanges (HIEs) for the purpose of facilitating the secure exchange of your health information between other health care entities for treatment, payment, and health care operations purposes. For example, we may use the health information that is available about you in an HIE to help us better understand your medical history so that we can provide you with the most appropriate treatment for your condition. This can also prevent you from having to undergo unnecessary tests and treatment. We may also disclose the information we have about you to the HIE to allow your other health care providers to do the same. If you do not wish to allow your other health care providers to see the health information we have created about you, you can opt out of participation in the HIE by informing our Privacy Officer in writing of your desire to opt-out of the HIE.

•**Litigation, Subpoenas, and Court Orders.** We may disclose your health information in response to a court or administrative order, subpoena, discovery request, or other lawful process. In some cases, the law also permits us to disclose your substance use disorder health information if the appropriate subpoena and court order have been provided to us or in cases where you have agreed to such a disclosure as a condition of a criminal proceeding you are involved in. With the appropriate order, a court may also require us to disclose confidential communications you have made as part of your diagnosis, treatment, or referral for treatment for a substance use disorder if it is necessary to protect someone from serious bodily injury, child abuse and neglect.

•**Law Enforcement.** We may disclose limited health information about you when requested by law enforcement officials. For example, we may be asked by law enforcement to provide your health information to assist in their location of a criminal suspect, fugitive, material witness, or the victim of a crime, or to report a gunshot wound or a suspicious death. We can also share your health information with law enforcement, including health information related to a substance use disorder, in cases where we need to report a crime that has occurred at our Facility or against one of our workforce members.

•**Correctional Institutions.** We may disclose your health information to correctional institutions and law enforcement officials if you are an inmate and the disclosure is necessary for your continued treatment or to protect the health or safety of others.

•**Military and Veterans.** If you are a member of the armed forces, we may, in limited circumstances, disclose your health information to your military commander and various government agencies that oversee the military.

•**Specialized Government Functions.** We may disclose your health information to authorized federal officials for intelligence, counterintelligence, and other national security activities, and for the provision of protective services to the President or foreign heads of state.

•**To Avoid a Serious Threat to Health or Safety.** We may use and disclose your health information to appropriate persons, including law enforcement, to prevent or lessen a serious threat to the health or safety of a person or the public. In certain circumstances, state law may require such a disclosure.

•**Organ and Tissue Donations.** We may disclose your health information to organizations for the purpose of organ, tissue, and eye donations and transplants.

•**Coroners, Medical Examiners and Funeral Directors.** We may disclose your health information to a coroner or medical examiner to help confirm your identity or cause of death. We may also disclose your health information to a funeral director if needed to make funeral arrangements.

•**Public Health and Safety.** We may disclose health information for public health and safety purposes. For example, we may be required to disclose your health information if you are a victim of abuse, neglect, or domestic violence. We may also disclose your health information in accordance with state law requirements, such as reporting births, deaths, or reactions to certain medications, or in an emergency or for disaster relief purposes. We may also release your health information to help control the spread of disease or to notify a person whose health or safety may be threatened. If we disclose your substance use disorder health information for public health and safety purposes, we must de-identify your information to ensure you cannot be identified by the information before we disclose it.

•**Health Oversight Activities.** We may disclose your health information, including your substance use disorder health information, to the government for health oversight activities authorized by federal or state law, such as audits, investigations, inspections, licensure and disciplinary actions or other activities necessary for monitoring the health care system, government programs, and our compliance with the law.

•**Workers' Compensation.** We may disclose your health information if permitted by state workers' compensation or similar laws.

•**Subsequent Disclosures.** Once your health information, including substance use disorder health information, has been disclosed to us or our Business Associate or Qualified Service Organization, we may further use and disclose such health information without your permission to the extent allowed by federal and state law.

AUTHORIZED ONLY DISCLOSURES

Sometimes federal or state laws require that we obtain your permission to use or disclose specific types of health information, even for purposes that might be permitted by other laws. For example, if we are your substance use disorder health care provider that is subject to these laws, we may only use and disclose your health information that is related to your diagnosis, treatment, or referral for treatment for a substance use disorder with your permission, except in limited situations that we explained elsewhere in this Notice. In some cases, state law may also require we obtain your permission before we can disclose specific medical information to others. If your permission is required by federal or state law, we will obtain your written authorization before we use or disclose your health information. In the following cases, we must, under most circumstances, have your permission to use and disclose your health information:

•**At Your Request.** You have the right to direct us to disclose your health information, including your substance use disorder health information, to persons or entities of your choosing. You must make these requests in writing and present them to our Health Information Management Department for processing. We may charge fees to cover the cost of making copies of your records in accordance with amounts allowed by federal or state law.

•**Fundraising.** We will not use or disclose your health information, including your substance use disorder health information, for fundraising purposes unless we have received your written permission prior to using or disclosing your health information for this purpose. You have the right to request not to receive fundraising communications.

•**Marketing.** We will not use or disclose your health information, including your substance use disorder health information, for marketing purposes unless we have received your written permission prior to using or disclosing your health information.

•**Sale of Health Information.** We will never sell your health information or substance use disorder health information unless we have received your written permission prior to such disclosure of your health information.

•**Medical Research.** We may participate in medical research studies. In most cases, we are required to obtain your permission to use your health information, including substance use disorder health information, unless an

Institutional Review Board has indicated that your permission is not required due to the protections that are in place to ensure the privacy of your health information during the research study.

•**Psychotherapy Notes/Substance Use Disorder Counseling Notes.** Psychotherapy notes and substance use disorder counseling notes are notes that your psychiatrist or psychologist maintained separate and apart from your medical record. These notes require your written authorization for disclosure unless the disclosure is required or permitted by law.

•**Other Uses and Disclosures of Your Substance Use Disorder Health Information.** As described above, federal law limits how we can use or disclose your substance use disorder health information our Facility has generated if we provide that type of treatment, or if we obtain that type of information from another provider who has provided you with that type of treatment. In the sections above, we have described when we can use and disclose your substance use disorder health information without your permission. However, in other situations, we must obtain your permission before we can use or disclose your substance use disorder health information. You are not required to give us permission. If you do give us permission, we will ask you to sign a written authorization form allowing the disclosure(s). You have the right to revoke your authorization at any time by notifying the Privacy Officer at our Facility in writing of your intent to revoke your authorization. Please note that your revocation will not impact any uses or disclosures of your substance use disorder health information that we made prior to our receipt of your written revocation of your authorization. Under federal law, in addition to the uses and disclosures already described in this Notice, we must obtain your permission before we can use or disclose your substance use disorder health information for the following specific purposes:

- **Treatment, Payment, and Healthcare Operations.** As explained in more detail in the section above, we use and disclose your general health information to treat you, to work with your insurer to obtain payment for your treatment, and for our business and operational purposes without your permission. However, if we are your substance use disorder health care provider, we must obtain your permission to use your substance use disorder health information for these purposes. If you wish to give us permission to use your substance use disorder health information for these purposes, federal law gives you the ability to give us a single written authorization allowing us to use and disclose your substance use disorder health information for all future treatment, payment, and health care operations purposes. Please note that if we disclose your substance use disorder health information with your permission for these purposes to another health care provider, including a provider that provides substance use disorder treatment, to a health plan, or to a health care clearinghouse, or to a Business Associate or Qualified Service Organization, they may further use and disclose your information without your permission as long as their use and disclosure of your information is in compliance with other federal healthcare privacy laws, except for uses and disclosures for civil, criminal, administrative, and legislative proceedings against you.

- **Civil, Administrative, Criminal, or Legislative Proceedings.** Your substance use disorder health information, and any verbal testimony about your substance use disorder health information will not be used or disclosed in any civil, administrative, criminal, or legislative proceedings against you without your consent or a valid court order accompanied by a subpoena or similar legal mandate compelling disclosure of that information. If we receive a court order, we will not use or disclose your substance use disorder health information until you or the person holding your information has had an opportunity to be heard and make objections if required by law.

- **Central Registry or Withdrawal Management Program.** With your permission, your substance use disorder health information can be shared with a central registry or a withdrawal management or maintenance treatment program to prevent your enrollment in multiple programs. These programs are prevented from using or disclosing the information they receive for any other purpose other than the purpose for which they received it and to ensure the appropriate coordination of your care.

- **Criminal Justice System.** With your permission, your substance use disorder health information can be disclosed to persons within the criminal justice system when your participation in substance use disorder treatment is a condition of a criminal proceeding you are involved in.

- **State Prescription Drug Monitoring Programs.** With your permission, your substance use disorder health information can be disclosed to a state prescription drug monitoring program to report medications prescribed or dispensed to you.

•**Other Purposes.** If we need to use or disclose your health information, including your substance use disorder health information, for any other reasons not described in this Notice, we will obtain your permission before we do so.

YOUR RIGHTS WITH RESPECT TO YOUR HEALTH INFORMATION
Federal and state laws provide you with the following rights with respect to your health information, including substance use disorder health information:

•**Right to Request Limited Use or Disclosure of Your Health Information.** You have the right to request that we do not use or disclose your health information, including your substance use disorder health information, for treatment, payment, or healthcare operations purposes.

We must grant your request to restrict disclosures to your health insurer if:
- the disclosure is for the purpose of carrying out payment or health care operations and is not required by law; and
- the health information or substance use disorder health information pertains solely to a healthcare item or service that you, or someone else other than your health insurer, has paid us for in full.

However, in other situations, we are not required to grant your request and may deny your request if it would compromise our ability to provide you with treatment, to obtain payment for your treatment, or to operate our Facility. If we deny your request, we will let you know of our decision in writing. If we do agree to your request, we must abide by the agreement.

•**Right to Confidential Communications of Your Health Information.** You have the right to request that your health information, including substance use disorder health information, be delivered to you by a confidential communication at an email or physical address you provide. Your request must be in writing, provide us with the confidential email or physical address you wish to use, and explain if the request will interfere with your method of payment.

•**Right to Revoke Your Authorization.** You may revoke, in writing, any authorization you have given us to use or disclose your health information, including substance use disorder health information. Your revocation will not impact any uses or disclosures of your health information or substance use disorder health information that we made prior to our receipt of your written revocation of your authorization.

•**Right to Access Your Health Information.** You have the right to physically inspect and/or request a paper or electronic copy of your health information, including substance use disorder health information, which is kept within your designated record set. You must make such a request in writing using our designated authorization form and provide it to our Health Information Management Department for processing. You can ask that copies be provided directly to you or to another person you have identified in your authorization. We will respond to your request within the time required by federal or state law, whichever is shorter. We may charge fees to cover the cost of making copies of your records or providing them to you in an electronic format in accordance with

amounts allowed by federal or state law. In limited instances, the law allows us to deny you access to your health information, including substance use disorder health information. If this is the case, we will provide you with the reason for our denial in writing and you may have a right to have our decision to deny your access reviewed.

•Right to Amend Your Health Information. You have the right to request that your health information, including your substance use disorder health information, be amended if you believe that it is inaccurate. You must make such a request in writing and provide it to our Health Information Management Department for processing. We may deny your request, but if we do so, we will tell you why in writing. You can submit a statement of disagreement, and if needed, we may prepare a counterstatement. Your statement of disagreement and our counterstatement will be made part of your medical record.

•Right to an Accounting of Disclosures. You have the right to request an accounting of certain disclosures we have made of your health information over the past six years and of certain disclosures of your substance use disorder health information for the past three years. We are not required by law to account for all disclosures of your health information and substance use disorder health information we have made, but we will provide you with an accounting of the required disclosures and the information relevant to those disclosures as required by law. You may receive one accounting of these disclosures per year free of charge but may be charged a fee for additional request made during the year. We will inform you if there is a charge and you have the right to withdraw your request or pay to proceed.

•Right to List of Disclosures Made By an Intermediary. You have the right to a list of disclosures of your substance use disorder health information that have been made by an intermediary for the past three years.

•Right to Be Notified of a Breach of Your Health Information. You have the right to be notified following a breach of your unsecured health information and substance use disorder health information. We will provide you with this notification within the timelines and as required by federal and state law.

HOW TO FILE A COMPLAINT REGARDING A VIOLATION OF THE PRIVACY OR SECURITY OF YOUR HEALTH INFORMATION OR OF YOUR RIGHTS CONCERNING YOUR INFORMATION

Uses and disclosures of your health information in violation of federal and state law may be a crime. If you believe there has been a violation of the privacy or security of your health information, your substance use disorder information, or of your rights concerning this information, we encourage you to file a complaint with our Privacy Officer in one of the following ways:

- In person at our Facility by asking for our Facility Privacy Officer
- By email at privacy@uhsinc.com
- By calling our Compliance Hotline toll-free at 1-800-852-3449

You may also file a complaint with the Secretary of Health and Human Services in the following ways:

- By mail at 200 Independence Ave., S.E., Room 509F HHH Bldg. Washington, D.C. 20201
- By email at OCRComplaints@hhs.gov
- Online at https://www.hhs.gov/hipaa/filing-a-complaint/index.html

If the suspected violation involves your substance use disorder health information, you may also file a complaint with the Substance Abuse and Mental Health Services Administration (SAMHSA) in the following ways:

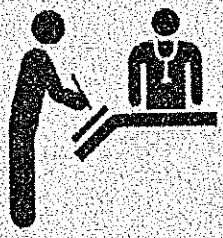
- By mail at 5600 Fishers Lane, Rockville, MD 20857
- By email at SAMHSAInfo@samhsa.hhs.gov

- By calling toll-free 1-877-SAMHSA (877-726-4727); TTY 800-487-4889

We will not retaliate against you for filing a complaint.

FOR THE BEST CARE, ENROLL TO SHARE

Join CommonWell and give your health care providers more secure access to your health records, no matter where the information is. They'll be able to make better decisions by sharing information about your health so you get the care you deserve.



ENROLL TODAY IT'S EASY!

When asked, let Registration know that you would like to participate in CommonWell.

commonwell HEALTH ALLIANCE

FOR THE BEST CARE, ENROLL TO SHARE

How many times have you had to list your allergies, medications and medical history? Wouldn't it be great if all of your doctors had instant and secure access to your medical information? No more carrying health records back and forth. No more recalling what your last lab results or medications prescribed were.

When you enroll in CommonWell Health Alliance® Services, you're enabling your health care providers to access information they may need to care for you.

WHAT ARE THE COMMONWELL SERVICES?

A free, more secure service that makes your health information available to your doctors regardless of where you've received care. Simply enroll in the service with a government-issued photo ID, and then confirm the other CommonWell doctors where you have been seen.

HOW DOES COMMONWELL HELP YOU?

- **Helps your doctors share information** — Allows your different doctors – primary care providers, specialists, hospitals and more – to have more secure, near instant access to your important health information. This includes health facilities you may visit near home as well as while you are traveling in the US.
- **Gets you faster and better care** — With less time wasted on tracking down your test results and other health information, your health care providers can treat you more efficiently, spending less time on paperwork and more time on your care.
- **Supports you in case of emergency** — There may be a time when you don't have the ability to gather or share your health information. Medical staff could immediately pull your allergies, medications and health problems, helping them care for you without delay.
- **Protects your data** — Electronic sharing is more secure than a fax or paper file, which could be easily lost or viewed with no tracking of who accessed that paper record.
- **Reduces paperwork and hassle.** Save time and the hassle of filling out the same health history forms over and over when you see new doctors or go to a specialist in the CommonWell network. Your latest health information will be right at their fingertips.

commonwell
HEALTH ALLIANCE

SUMMERLIN HOSPITAL
MEDICAL CENTER

Patient Rights and Responsibilities

Summerlin Hospital Medical Center is committed to providing high quality health care in compliance with law and regulations. We strongly believe that every patient deserves to be treated with respect, dignity, and concern. We will provide care regardless of race, creed, sex, sexual orientation, gender identity, or expression, national origin, religion, impairment, or source of payment.

We consider a patient a partner in their health care. When patients are well informed, participate in treatment decisions, and communicate openly with their doctor and other health professionals, they help make their care as effective as possible. Summerlin Hospital Medical Center encourages respect for the personal preferences and values of each individual. It is our goal to assure that patient's rights are observed and to act as a partner in their decision-making process. It is in recognition of these factors that these rights are affirmed.

Patient Rights shall include but not limited to:

Access to Care

- Exercise these rights without regard to sex, sexual orientation, gender identity, or expression, cultural background, economic status, education, religion and disability, including AIDS and related conditions, or the source of payment for their care.
- Reasonable responses to any reasonable request they may make for service.

Respect and Dignity

- Care that respects their personal values and beliefs, access to spiritual care and respect of spiritual and cultural beliefs.
- Know which Summerlin Hospital Medical Center rules and policies apply to their conduct as a patient.
- To question any of these rights by contacting a health care provider or Administration.

Privacy

- Full consideration of personal privacy concerning their medical care program. Case discussion, consultation, examination, and treatment are confidential and shall be conducted discreetly. The patient has the right to be advised as to the reason for the presence of any care provider.
- Confidential treatment of all communication and records pertaining to their care and stay at Summerlin Hospital Medical Center to the extent provided by law. The patient has the right to access information contained in their record within a reasonable time frame. The patient has the right to inquire regarding access to their personal health information.
- Information regarding the privacy and confidentiality practices of Summerlin Hospital Medical Center as provided by law.

Transfer and Continuity of Care

- Reasonable continuity of care and to know in advance the time and location of appointment, as well as the physician providing care.
- Be informed by their physician or a delegate of their continuing health care requirement following their discharge from Summerlin Hospital Medical Center.

Safety

- Considerate and respectful care in a safe setting, free from any form of abuse, neglect, exploitation or harassment.
- Access to Protective and Advocacy Services.

Information

- Become informed of his or her rights as a patient in advance of provision of care or as soon as reasonably possible. The patient may appoint a representative to receive this information he or she so desires.
- Freedom of choice of physician. Knowledge of the name of the physician who has primary responsibility for coordinating their care and the name and professional relationships of other physicians who will see them.

Communication

- Receive information in a manner that they can understand. This includes the provision of an interpreter and if the patient is hearing impaired, access to TDD.
- Receive information from their physician about their illness, course of treatment, outcomes of care (including unanticipated outcomes) and prospects for recovery in terms that they can understand.
- Have all patient rights apply to the person who may have legal responsibility to make decisions regarding medical care on behalf of the patient.

Advance Directive

- Receive information regarding their right to forgo or withdraw life-sustaining treatment and to formulate a declaration (advance directive or living will) and/or durable power of attorney for health care provided for in the Nevada Revised Statutes 449.535 to 449.690 inclusive (Uniform Act on Rights of the Terminally Ill).
- The patient has the right to have his or her declaration (advance directive), if any directive has been executed, made a part of their permanent medical record. The patient has the right to review and revise their declaration (advance directive).
- The patient has the right to receive care without discrimination regardless of whether or not they have or have not executed a declaration (advance directive).
- The patient has the right to have the terms of their declaration (advance directive) complied with by the health care facility and caregivers to the extent permitted by law.

Pain Management

- To have pain assessed and to have pain treated appropriately. The patient has the right to receive education regarding their role in pain management and the potential limitations and side effects of pain treatments.

Consent

- Participate in decisions regarding their medical care and in resolving dilemmas about care, treatment, and services. To the extent permitted by law, this includes the right to accept or refuse medical or surgical treatments.
- Receive as much information about any proposed treatment or procedure as may be needed to give information consent or to refuse the course of treatment (to the extent permitted by law). Except in an emergency, the information provided to the patient shall include, but not necessarily be limited to, a description of the procedure or treatment, the medically significant benefits, risks, or side effects, including potential problems related to recuperation, alternate course of treatment or non treatment and the risks involved in each, and the likelihood of achieving treatment or care goals. The patient has the right to know the name and person responsible for all procedures and treatments.
- The patient has the right to have his or her care transferred to another doctor or health care facility if their doctor(s) or agent of their doctor(s), or the health care facility cannot respect their declaration (advance directive) requests as a matter of "conscience".
- Leave Summerlin Hospital Medical Center, even against the advice of their physicians.
- Be advised if Summerlin Hospital Medical Center or personal physician proposes to engage in research, educational projects or human experimentation affecting their care or treatment. The patient has the right to refuse to participate in such research projects or to discontinue participation, at anytime, in a research or investigational project without compromising access to care, treatment or services.

Grievances

- To communicate any complaints or concerns that arise in the provision of care. A grievance or complaint may be communicated verbally, in person, by phone, or in writing to the Patient Advocate.

Hospital Charges

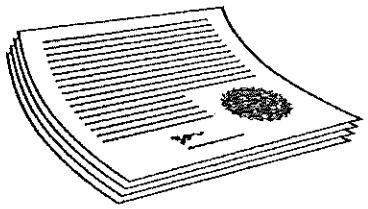
- Examine and receive an explanation of their bill, regardless of source of payment.

Responsibilities

At Summerlin Hospital Medical Center, we feel that we are entitled to reasonable and responsible behavior, considering the nature of the illness, on the part of the patients and their families. In order to make treatment as effective as possible and to improve the quality of life, Summerlin Hospital Medical Center asks patients to take specific responsibilities in the daily management of their hospital stay. These responsibilities include but are not limited to the following:

- Providing Summerlin Hospital Medical Center with accurate and complete information about present complaints and condition, past medical history, medications and other matters related to the patient's health.
- Informing healthcare providers how the patient and/or caregivers want to be involved in their treatment and care.
- Working together with the healthcare team to develop a plan of care and following the plan developed.
- Following through with what they agree to do in their treatment plan. If they cannot follow the plan, they shall inform the healthcare providers.
- Assuming responsibility for their own actions if they refuse treatment or do not follow the treatment instructions.
- Informing their healthcare providers whether they understand the planned course of treatment.
- Report any unexpected changes in their condition to healthcare providers.
- Knowing what medications they are taking and why and asking the healthcare provider when they are uncertain.
- Informing the healthcare provider when they are in pain.
- Providing Summerlin Hospital Medical Center staff any advance directives or Durable Power of Attorney for Healthcare. The patient is responsible for understanding the consequences of refusing medical treatment.
- Following the rules and regulations of Summerlin Hospital Medical Center affecting patient care and personal conduct.
- Being considerate of the rights and property of other patients, families and Summerlin Hospital staff and assisting the control of noise, smoking, and distractions. Abusive language and threatening behavior will not be tolerated.
- Making sure financial obligations for health care provided are fulfilled as promptly as possible.
- Communicating suggestions or improvements regarding their healthcare services.

SUMMERLIN HOSPITAL
MEDICAL CENTER



Dear Summerlin Hospital Medical Center Patient:

The Health Information Management Department would like to refrain from copying your medical records at this time due to the incomplete status of your chart. At this point in time, your medical record does not represent the entire episode of your care with us at Summerlin Hospital Medical Center. In order to furnish you with the most complete and accurate medical record possible, please refer to the following:

To obtain a copy of your medical records for *personal use*:

1. Obtain an Authorization for Release of Protected Health Information from the Nursing Station prior to your departure from the facility.

   In the event that you do not obtain one prior to leaving the Nursing unit, please use one of the following options:

   - Go to the Health Information Management Department.
   - Contact the Health Information Management Department via a phone and request that one be mailed or faxed to you for completion.
   - Visit www.valleyhealthsystemlv.com and select the link for "Obtaining Medical Record." Go to patient & visitor tab and select link for "Obtaining Medical Records."
   - Visit www.rollog.com and click Authorization Forms, locate Nevada, SHMC, and select the appropriate form.

2. Complete the Authorization For Release Of Protected Health Information Form.
3. Record requests take between seven (7) and ten (10) business days to process, but not to exceed 30 days.
4. There will be a charge of $6.50 for copies of PHI maintained electronically and requested in an electronic format (email or CD-ROM) for releases of PHI for all reasons other than continued patient care. For copies of PHI provided on paper, there will be a charge of $0.10 per page.

To obtain a copy of your medical records for *continued care*:

1. Go to your physician's office on the day of your appointment.
2. Ask them to send a request for your medical records on their office letterhead.
3. Ask them to fax this request to us at 233-7916.
4. The Health Information Management Department will fax your medical records to your physician within 15-30 minutes of its receipt of your request.

Now...get your medical records... 24 hours a day, 7 days a week

Your email address gets you online access to your medical records.
Health Records Online is a secure, online service from the Valley Health System that lets you view select medical records online. All you need is a computer and an internet connection to see your healthcare records, including:

- Allergies
- Completed procedures
- Health Issues
- Immunizations
- Medications

You will be able to view and download discharge instructions and summaries of the care you received at Valley Health System to provide to your personal physician or other healthcare provider. You may even be able to forward the summary of your care directly to your healthcare provider.

Now that your account has been created, to view your records go to: https://west.uhspatientportal.com

Thank you very much for your cooperation and understanding.

Health Information Management Department
Summerlin Hospital Medical Center
657 Town Center Drive
Las Vegas, NV 89144
(702) 233-7580

The Valley Health System

Notice of Reduction or Discount

Notice of the reduction or discount available pursuant to NRS 439B.260, including, without limitation, notice of the criteria a patient must satisfy to qualify for a reduction or discount under that section.

The Valley Health System extends an uninsured, 60% discount off total billed charges for all patients who reside in the United States with no insurance coverage. This discount pertains to non-elective procedures only. It is the responsibility of the patient or legal guardian to make payment arrangements on the account within 30 days of discharge.

The Valley Health System has a Charity Care Program available to uninsured, eligible inpatient and outpatients who meet the established criteria;

- Income less than or equal to 400% of the federal poverty guideline.
- Application must be submitted for review.

Centennial Hills Hospital
Desert Springs Hospital
Henderson Hospital
Spring Valley Hospital
Summerlin Hospital
Valley Hospital
West Henderson Hospital

Notice of Availability of Language Assistance Services & Auxiliary Aids

ENGLISH – ATTENTION: Language assistance services and auxiliary aids are available to you at no charge.

AMHARIC – ያስተውሉ:- የቋንቋ እገዛ አገልግሎቶችን እና መርጃ መሣሪያዎችን ያለ ምንም ክፍያ ማግኘት ይችላሉ።

ARABIC – تنبيه: خدمات الترجمة والمساعدة اللغوية، بالإضافة إلى الوسائل المساعدة، متوفرة لك مجانًا

ARMENIAN – *Ուշադրություն: Լեզվական օգնության ծառայությունները և օժանդակ միջոցները հասանելի են Ձեզ համար անվճար:*

BANTU-KIRUNDI – ICITONDERWA: Ibikorwa vyo gufasha mu vyerekeye ururimi n'ibikoresho vy'inyinyongera vyo gufasha birahari ku buntu.

BASSA – CMR Bassa (Cameroon Bassa): Njaŋ nɛ: Nduŋ mɛ tebu ŋgɛ mɛ nɛ m̀ bɔ̀ɔ̀ŋ yèŋ lɛ̌ nà ŋgɔ̀ nà wɛ̀ kɛ́ m̀ mɔ́, mà kɛ̌ tè mɛ̌ wɛ́.

Liberian Bassa: Leh-mah: Wrokɔ-lu nì kpɛ́ɛnɛ wɔ́ɖa nì bɔ̀ nì kɔ̀ sà, gbɛɛ̀ ɖɛɛ̀ à ɖɛ́ nyɛ̀, màa ɖɛ sù sáa.

BENGALI – মনে রাখবেন: ভাষার জন্য সহায়ক পরিষেবা এবং বাড়তি সহায়তা আপনার জন্য বিনামূল্যে উপলভ্য।

BURMESE – ဂရုပြုရန်- ဘာသာစကားအကူအညီပေးရေး ဝန်ဆောင်မှုများနှင့် အရန်အကူအညီများကို အခမဲ့ ရယူနိုင်ပါသည်။

CAMBODIAN – ការយកចិត្តទុកដាក់៖ សេវាកម្មជំនួយភាសា និងឧបករណ៍ជំនួយអ្នកមានបញ្ហាការស្រែយមានគ្រប់ អាចផ្តល់ជូនអ្នកដោយមិនគិតថ្លៃ។

CHEROKEE – OySVTS: DLO᏶VT SVOᏃZBᏫᏍᏗ OᏙVPRT DᏅ OᏓOᏌVT DᏍᏆLS OᏙVPRT ᎾᏍᎩ DᏅ ᏧOᏌVTᏍᏗ ᏱY TSRᏗ DᏅ OᏙᎾᏓᏤET.

CHINESE TRADITIONAL – 注意：您可以免費獲得語言輔助服務和輔助工具

DUTCH – Achtung: Sprachhilfedienste un Hilfsmittel sin für euch kostenlos verfügbar.

CHOCTAW – AHVLLA: Anumpuli isht aiittanaha anumpuli tuklo isht anoli aiimpa chito micha isht anokfilli atoksvli tuk achukma, ish hohchifo yohmi aiimpa tuk.

FARSI – توجه: خدمات کمک زبانی و وسایل کمکی به‌صورت رایگان در اختیار شما قرار می‌گیرد.

FRENCH – ATTENTION : des services d'assistance linguistique et des aides complémentaires sont mis gratuitement à votre disposition.

FRENCH-CREOLE – ATANSYON: Sèvis asistans lang ak èd siplemantè disponib pou ou san frè.

GERMAN – HINWEIS: Hilfsmittel und Sprachassistenz stehen Ihnen kostenfrei zur Verfügung.

GREEK – ΠΡΟΣΟΧΗ: Οι υπηρεσίες γλωσσικής υποστήριξης και τα βοηθητικά μέσα είναι στη διάθεσή σας στη διεύθυνση χωρίς χρέωση.

GUJARATI – ધ્યાન રાખો: ભાષા સહાયતા અંગેની સેવાઓ અને સહાયક સાધનો તમારા માટે નિ:શુલ્ક ઉપલબ્ધ છે.

HEBREW – לב שימו: שירותי סיוע בשפה ועזרים נלווים זמינים עבורכם ללא תשלום.

HINDI – ध्यान दें: भाषा सहायता सेवाएं और सहायक साधन आपके लिए निःशुल्क उपलब्ध हैं।

HMONG – CEEB TOOM: Cov kev pab cuam txhais lus thiab cov cuab yeej khoom siv pab muaj rau koj yam tsis tau them nqi.

ILOCANO – IPANGAG: Dagiti serbisio a tulong iti pagsasao ken dagiti katulongan a tulong ket magun-odanyo nga awan bayadna.

IGBO – GEE NTỊ: Ọrụ enyemaka asụsụ nakwa nkwado ihe enyemaka dịrị gị na-akwụghị ụgwọ ọbụla.

INDONESIAN – PERHATIAN: Layanan bantuan bahasa dan alat bantu tambahan tersedia untuk Anda tanpa biaya.

ITALIAN – ATTENZIONE: I servizi di assistenza linguistica e gli ausili sono disponibili gratuitamente.

KURDISH – Kurdish Sorani: سەرنج: خزمەتی یارمەتی زمان و یارمەتی لاوەکی بەلاش بۆ تۆ بەردەستە
Kurdish Kurmanji: Agahî: Xizmeta alîkarîya zimn û alîkarîyên yedek ji bi awayeke bêpere ji we re berdest e.

JAPANESE – ご案内：言語支援サービス及び補助機器を無料でご利用いただけます。

KOREAN – 주의: 언어 지원 서비스와 보조 도구는 무료로 사용 가능합니다.

LAO – ໝາຍເຫດ: ບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ ແລະ ເຄື່ອງຊ່ວຍເຫຼືອແມ່ນມີໃຫ້ທ່ານໂດຍບໍ່ເສຍຄ່າ.

NAVAJO – BAA'ÁKONÍNÍZIN: T'áá shika' áyóo nihá níl hóló holne' doo bee nihásh'á yáhoot'éego bina'nitin dóó bił haz'á áká'ánígíí t'áá jíík'ehgo t'áá hóló

NEPALI – ध्यान दिनुहोस्: तपाईंका लागि भाषा सहायता सेवाहरू र सहायक उपकरणहरू निःशुल्क रूपमा उपलब्ध छन्।

PENNSYLVANIA DUTCH – Achtung: Sprachhilfsdienste und Unterstützungsangebote sin für eich umsonst verfügbar.

PUNJABI – ਧਿਆਨ ਦਿਓ: ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਅਤੇ ਸਹਾਇਕ ਸਾਧਨ ਤੁਹਾਡੇ ਲਈ ਮੁਫ਼ਤ ਵਿੱਚ ਉਪਲਬਧ ਹਨ।

POLISH – UWAGA: Usługi pomocy językowej i materiały pomocnicze są dostępne bezpłatnie.

PORTUGUESE – ATENÇÃO: Os serviços de assistência linguística e as ajudas auxiliares estão à sua disposição gratuitamente.

ROMANIAN – ATENȚIE: Serviciile de asistență lingvistică și mijloacele auxiliare sunt disponibile gratuit.

RUSSIAN – ВНИМАНИЕ: Услуги языковой поддержки и вспомогательные средства доступны для вас бесплатно.

SAMOAN – FAAMATALAGA: O lo'o avanoa fua mo oe auaunaga fesoasoani i le gagana ma fesoasoani fa'aopoopo.

SERBO-CROATIAN – PAŽNJA: Usluge jezičke pomoći i pomoćna sredstva dostupni su vam besplatno.

SPANISH – ATENCIÓN: los servicios de asistencia lingüística y las ayudas auxiliares están disponibles para usted de manera gratuita.

SOMALI – DIGNIIN: Adeegyada caawinta luqadda iyo qalabka gacan-siinta waa laguu heli karaa bilaash.

SWAHILI – TAFADHALI FAHAMU: Huduma za usaidizi wa lugha na vifaa vya kusaidia vinapatikana kwako bila malipo.

TAGALOG – FILIPINO – PAUNAWA: May inilalaan na mga pantulong sa pagsasalin ng wika, tulong sa pandinig, o tulong sa pagbabasa para sa inyo nang walang bayad.

TELUGU – గమనిక: భాషా సహాయ సేవలు మరియు సహాయక సహాయాలు మీకు ఉచితంగా అందుబాటులో ఉన్నాయి.

THAI – หมายเหตุ บริการช่วยเหลือด้านภาษาและบริการเสริมอื่น ๆ เปิดให้ใช้บริการแล้วโดยไม่มีค่าใช้จ่ายเพิ่มเติม

TONGAN – TOKANGA: Ko e ngaahi sevesi tokoni ki he lea mo e ngaahi tokoni 'oku 'ataa ia kiate koe 'o 'ikai ha totongi.

UKRANIAN – УВАГА: Мовні послуги та допоміжні засоби доступні для вас безкоштовно.

URDU – توجہ فرمائیں: زبان میں معاونت کی خدمات اور امدادی سہولیات آپ کے لیے بلا معاوضہ دستیاب ہیں۔

VIETNAMESE – LƯU Ý: Dịch vụ hỗ trợ ngôn ngữ và các phương tiện bổ trợ được cung cấp miễn phí cho bạn.

YORUBA – ÌKÍLỌ̀: A ń pèsè ìrànlọ́wọ́ ìtúmọ̀ èdè àti àwọn ohun èlò àfikún fún ọ láìsanwó.