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

Pre-Registration for Maternity Patients

Thank you for pre-registering with
The Birthplace at Summerlin Hospital

We are excited you have chosen us to
care for your growing family.

Instructions

- ☐ Please sign and date ALL forms included in this packet
- ☐ Once completed & signed, please have your picture I.D. & Insurance Card(s) ready
- ☐ Return this packet to the Admitting Department

Childbirth Education classes are available to all expecting parents. Please email: SummerlinBirthplace@uhsinc.com for more information on available childbirth classes.

SUMMERLIN HOSPITAL MEDICAL CENTER

Maternity Pre-Registration

PATIENT INFORMATION (Please write Legibly)

Patient Name: _____ Date of Birth: _____

Home Address: _____ Home Phone: _____

Apt. No/Ste: _____ Cell Phone: _____

City: _____ State: _____ Zip Code: _____

Social Security#: _____ Email Address : _____

Race: _____

Marital Status: ___Married __Single __ Divorced __Widowed Religious Preference: _____

Country of Birth: _____ Primary Language: _____

Employer Name: _____ Occupation: _____

Employer Address: _____ Employer Phone: _____

City: _____ State: _____ Zip Code: _____

EMERGENCY CONTACT

Name: _____ Relationship To Patient: _____

Address: _____ Home Phone: _____

City: _____ State: _____ Zip Code: _____ CELL#: _____

INSURED INFORMATION

Primary Subscriber Information:

Name: _____ Relationship to patient: _____

Date of Birth _____ Social Security: _____

Employer Name: _____ Occupation: _____

Address: _____ Insurance : _____

City: _____ State: _____ Zip Code: _____

Secondary Subscriber Information:

Name: _____ Relationship to patient: _____

Date of Birth _____ Social Security: _____

Employer Name: _____ Occupation: _____

Address: _____ Insurance: _____

City: _____ State: _____ Zip Code: _____

OB/Gyn Doctor: _____ Primary Physician: _____

Last Menstrual Period: _____ DUE DATE: _____

Scheduled Induction/C-section Date: _____

Conditions of Admission/Registration
Treatment Authorization and Financial Responsibility

As the individual who will be receiving services at Summerlin Hospital (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.

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:** I give the Hospital and its agents and/or other parties calling on behalf of the Hospital (including, but not limited to, debt collectors or others calling regarding your Hospital visit, government or charity care programs) permission to contact me by telephone at the telephone number or numbers **I provided during the registration process**, or at any time in the future, including wireless telephone numbers or other numbers that may result in charges to me. The Hospital and its agents may leave messages for me at these numbers and may send text messages or email communications using the email address or addresses I provide. These voice messages and email and text communications may include information required by law (including debt collection laws) related to amounts I owe the Hospital as well as messages related to my continued care and treatment.

    I also understand that the Hospital and its agents or other parties calling on the Hospital's behalf may use pre-recorded/artificial voice messages and/or use an automatic dialing devise (an auto-dialer) to deliver messages related to my Hospital visit, my account, whether I qualify for government programs, whether I qualify for charity care programs or amounts I may owe the Hospital. I also authorize the Hospital and its agents to use the number or numbers provided for such pre-recorded or auto dial messages. If I want to limit these communications to a specific telephone number or numbers, I understand that I must request that only a designated number or numbers may 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 AND VIDEO 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.

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.

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 _____

CO0058

COA/Reg Treatment Authorization and Financial Responsibility

UHS-9018
Rev. 04/2022

Patient Identification

DOB:
MRN:

SX:

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 MEDICAL CENTER

PATIENT SELF DETERMINATION RECORD

PART 1. ----------

Y / N Do you, the patient, have an advance directive for healthcare?

Y / N Do you, the patient, have an advance directive for behavioral healthcare?

Is the advance directive a living will?

Is the advance directive a durable power of attorney for healthcare?

PART 2.

Who is your appointed healthcare surrogate having your durable power of attorney for healthcare?

Name: Relationship:

Address: Phone: / -

City St: Zip: -

Does this person know and agree to be your healthcare surrogate?

If the person neither knows nor agrees to be your healthcare surrogate, do you still wish to designate an alternate healthcare surrogate? if so, we will have a hospital representative visit you and record your alternate healthcare proxy information.

contact date: 00/00/00

Representative contacted by:

PART 3. ----------

Y / N Would you like information regarding an advance directive since you do not have one?

PART 4. ----------

You, the patient state you have an advance directive.

Do you have a copy with you?

Did the hospital staff person make a copy and attach it to the chart?

PART 5. ----------

Patient wants additional information on advance directives.

You have received information regarding an advance directive.

You have been informed to advise your nurse if you want to create an advance directive while in the hospital.

PART 6. ----------

Since you do not have a copy of the advance directive on hand, where is the advance directive located? Location:

Can you have a copy brought to the hospital?

If someone can bring the copy, when will it be delivered to your nursing unit?

Date copy will arrive: 00/00/00 Date copy received: 00/00/00

PART 7. ---------- Contents of Advance Directive ----------

Pt Signature:_____ Date:_____ Time:_____

Witness Signature:_____ Hospital Rep:

The patient is incapable of answering the following questions because:

Date:_____ Time:_____

Signature and Title:_____

Pt No:

Mr No:

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 Summerlin 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**

Patient Identification

DOB:
MRN:

SX:

Patient Consent Form for Electronic Exchange of Individual Health Information

HealthHIE Nevada is a non-profit organization dedicated to connecting the healthcare community to share information electronically and securely to improve the quality of healthcare services. To learn more about the Health Information Exchange (HIE), read the Patient Information brochure. You can ask the doctor that gave you this form for it, or go to the website www.healthIEnevada.org.

Details about patient information in HealthHIE Nevada and the consent process:

1. **How your information will be used and who can access it:** When you provide consent, only HealthHIE Nevada participants (such as doctors, hospitals, laboratories, radiology centers, and pharmacies), will have access to your health information. It can only be used to:
   - Provide you with medical treatment and related services.
   - Evaluate and improve the quality of medical care provided to all patients, using de-identified health information.
2. **Types of information included and where it comes from:** The information about you comes from organizations that have provided you with medical care, and are HealthHIE Nevada participants. These may include hospitals, physicians, pharmacies, clinical laboratories, and other healthcare organizations. Your health records may include a history of illnesses or injuries you have had (like diabetes or a broken bone), test results (like X-rays or blood tests), and lists of medications your doctor has prescribed. This may include information created before the date of this Consent Form. This information may relate to sensitive health conditions, including but not limited to:
   - Alcohol or drug use problems
   - HIV/AIDS
   - Birth control and abortion (family planning)
   - Genetic (inherited) diseases or tests
   - Mental health conditions
   - Sexually transmitted diseases
3. **Improper Access or Disclosure of your Information:** Electronic information about you may be disclosed by a participating doctor to others only to the extent permitted by Nevada State Law. If at any time you suspect that someone who should not have seen or received information about you has done so, you should notify your doctor.
4. **Effective Period:** Your consent becomes effective upon signing this form and will remain in effect until the day you revoke it or HealthHIE Nevada ceases to conduct business.
5. **Revoking your consent:** At any time, you may revoke your consent by signing a new consent form and giving it to your doctor. These forms are available at your doctor's office, or by calling 855-484-3443. Changes to your consent status may take 24-48 hours to become active in the system.

Note: Organizations that access your health information through HealthHIE Nevada while your consent is in effect may copy or include your information into their own medical records. Even if you later decide to withdraw your consent, they are not required to return it or remove it from their records.

6. **How your information is protected:** Federal and State laws and regulations protect your medical information. HIPAA, the Healthcare Insurance Portability and Accountability Act of 1996, is the federal law that protects your medical records and limits who can look at and receive your health information, including electronic health information. HIPAA's protections were further strengthened by another federal law, the HITECH Act of 2009, which may impose severe financial fines on anyone who violates your medical privacy rights. All health information made available on the HIE, including your medical information, is encrypted to federal standards and is accessible only as allowed by Nevada State law (NRS 439.590). In addition, your doctor must provide you with a Notice of Privacy Practices, which describes how he or she uses and protects your medical information.

Copy of Form: You are entitled to receive a copy of this Consent Form after you sign it.

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.

PATIENT MEDICATION ASSISTANCE PROGRAM

Summerlin Hospital Medical Center may be able to obtain reimbursement for some of your medications from the companies that manufacture them. Most of these programs require your signature on the application forms. So that you do not have to sign an application for each medication, we are requesting that you execute this Limited Power of Attorney, which allows a Pharmacy Healthcare Solutions representative to sign these forms on your behalf.

LIMITED POWER OF ATTORNEY

I, _____ of _____
(Patient's Name)

_____
(Patient's Street Address, City, St & Zip)

hereby appoint a Pharmacy Healthcare Solutions Representative, my attorney in fact (my "Attorney") for the sole and exclusive purpose of executing, in my name, the application forms required, for Summerlin Hospital Medical Center to obtain replacement/reimbursement of my medications from pharmaceutical manufacturers.

This Power of Attorney shall be in full force from the date signed,

on, _____.

Signature: _____ Date: _____
(Patient's Signature)

Witness: _____ Date: _____
(Witness Signature)

RECEIPT OF NOTICE OF PRIVACY PRACTICES
FROM: SUMMERLIN HOSP MED CTR

Version Date: 266/13

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	Witness Job Title	

Respecting Your Privacy

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.

PROTECTED HEALTH INFORMATION

Information about your health is private. And it should remain private. That is why this healthcare institution is required by federal and state law to protect and maintain the privacy of your health information. We call it "Protected Health Information" (PHI).

The basis for federal privacy protection is the Health Insurance Portability and Accountability Act (HIPAA) and its regulations, known as the "Privacy Rule" and "Security Rule" and other federal and state privacy laws.

WHO WILL FOLLOW THIS NOTICE

This Notice describes the information privacy practices followed by our hospital, employees, volunteers, and related personnel.

The 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 contents. Many of our doctors follow the practices contained within this Notice. Other physicians have created their own Notice. Those members of the Medical Staff who opt not to abide by this Notice are required to give you a separate Notice that will explain their privacy practices.

Each participant who joins in this joint Notice of Privacy Practices serves as their own agent for all aspects of HIPAA Compliance, other than the delivery of this Joint Notice. For physician specific issues or questions, please feel free to contact your physician directly.

Hospital employees, volunteers, and related personnel, including those members of the Medical Staff who have opted to abide by its contents, must follow this Notice with respect to:

- How We Use Your PHI
- Disclosing Your PHI to Others
- Your Privacy Rights
- Our Privacy Duties
- Hospital Contacts for More Information or, if necessary, a Complaint

Your personal doctor may have different policies regarding the use and disclosure of PHI created in their offices.

USING OR DISCLOSING YOUR PHI:

FOR TREATMENT

During the course of your treatment, we use and disclose your PHI. For example, if we test your blood in our laboratory, a technician will share the report with your doctor. Or, we will use your PHI to follow the doctor's orders for an x-ray, surgical procedure or other types of treatment related procedures.

FOR PAYMENT

After providing treatment, we will ask your insurer to pay us. Some of your PHI may be entered into our computers in order to send a claim to your insurer. This may include a description of your health problem, the treatment we provided and your membership number in your employer's health plan.

Or, your insurer may want to review your medical record to determine whether your care was necessary. Also, we may disclose to a collection agency some of your PHI for collecting a bill that you have not paid.

FOR HEALTHCARE OPERATIONS

Your medical record and PHI could be used in periodic assessments by physicians about the hospital's quality of care. Or we might use the PHI from real patients in education sessions with medical students training in our hospital. Other uses of your PHI may include business planning for our hospital or the resolution of a complaint.

SPECIAL USES

Your relationship to us as a patient might require using or disclosing your PHI in order to

- Remind you of an appointment for treatment
- Tell you about treatment alternatives and options
- Tell you about our other health benefits and services
- Ask you to contribute to our charitable activities, unless you tell us not to ask. You have a right to opt out of receiving such communications.

YOUR AUTHORIZATION MAY BE REQUIRED

In many cases, we may use or disclose your PHI, as summarized above, for treatment, payment or healthcare operations or as required or permitted by law. In other cases, we must ask for your written authorization with specific instructions and limits on our use or disclosure of your PHI. This includes, for example, uses or disclosures of psychotherapy notes, uses or disclosures for marketing purposes, or for any disclosure which is a sale of your PHI. You may revoke your authorization if you change your mind later.

CERTAIN USES AND DISCLOSURES OF YOUR PHI REQUIRED OR PERMITTED BY LAW

As a hospital or healthcare facility, we must abide by many laws and regulations that either require us or permit us to use or disclose your PHI.

REQUIRED OR PERMITTED USES AND DISCLOSURES

- If you do not verbally object, we may include information identifying you in a visitors' directory of patients while you are an inpatient in our hospital. This information may include your name, general condition and religious affiliation, if any.
- If you do not verbally object, we may share some of your PHI with a family member or friend involved in your care.
- We may use your PHI in an emergency when you are not able to express yourself.
- We may use or disclose your PHI for research if we receive certain assurances which protect your privacy.

WE MAY ALSO USE OR DISCLOSE YOUR PHI

- When required by law, for example when ordered by a court.
- For public health activities including reporting a communicable disease or adverse drug reaction to the Food and Drug Administration.
- To report neglect, abuse or domestic violence.
- To government regulators or agents to determine compliance with applicable rules and regulations.
- In judicial or administrative proceedings as in response to a valid subpoena.
- To a coroner for purposes of identifying a deceased person or determining cause of death, or to a funeral director for making funeral arrangements.
- For purposes of research when a research oversight committee, called an institutional review board, has determined that there is a minimal risk to the privacy of your PHI.
- For creating special types of health information that eliminate all legally required identifying information or information that would directly identify the subject of the information.
- In accordance with the legal requirements of a Workers' Compensation program.
- When properly requested by law enforcement officials, for instance in reporting gun shot wounds, reporting a suspicious death or for other legal requirements.
- If we reasonably believe that use or disclosure will avert a health hazard or to respond to a threat to public safety including an imminent crime against another person.

- For national security purposes including to the Secret Service or if you are Armed Forces personnel and it is deemed necessary by appropriate military command authorities.
- In connection with certain types of organ donor programs.
- For surveys, including patient satisfaction surveys.

YOUR PRIVACY RIGHTS AND HOW TO EXERCISE THEM

Under the federally required privacy program, patients have specific rights.

YOUR RIGHT TO REQUEST LIMITED USE OR DISCLOSURE

You have the right to request that we do not use or disclose your PHI in a particular way. We must abide by your request to restrict disclosures to your health plan (insurer) if:

- the disclosure is for the purpose of carrying out payment or health care operations and is not required by law; and
- the PHI pertains solely to a healthcare item or service that you, or someone else other than the health plan (insurer) has paid us for in full.

In other situations, we are not required to abide by your request. If we do agree to your request, we must abide by the agreement.

YOUR RIGHT TO CONFIDENTIAL COMMUNICATION

You have the right to receive confidential communications of PHI from the hospital at a location that you provide. Your request must be in writing, provide us with the other address and explain if the request will interfere with your method of payment.

YOUR RIGHT TO REVOKE YOUR AUTHORIZATION

You may revoke, in writing, the authorization you granted us for use or disclosure of your PHI. However, if we have relied on your consent or authorization, we may use or disclose your PHI up to the time you revoke your consent.

YOUR RIGHT TO INSPECT AND COPY

You have the right to inspect and copy your PHI (or to an electronic copy if the PHI is in an electronic medical record), if requested in writing. We may refuse to give you access to your PHI if we think it may cause you harm, but we must explain why and provide you with someone to contact for a review of our refusal.

YOUR RIGHT TO AMEND YOUR PHI

If you disagree with your PHI within our records, you have the right to request, in writing, that we amend your PHI when it is a record that we created or have maintained for us. We may refuse to make the amendment and you have a right to disagree in writing. If we still disagree, we may prepare a counter-statement. Your statement and our counter-statement must be made part of our record about you.

YOUR RIGHT TO KNOW WHO ELSE SEES YOUR PHI

You have the right to request an accounting of certain disclosures we have made of your PHI over the past six years, but not before April 14, 2003. We are not required to account for all disclosures, including those made to you, authorized by you or those involving treatment, payment and health care operations as described above. There is no charge for an annual accounting, but there may be charges for additional accountings. We will inform you if there is a charge and you have the right to withdraw your request, or pay to proceed.

YOUR RIGHT TO BE NOTIFIED OF A BREACH

You have the right to be notified following a breach of unsecured PHI.

YOUR RIGHT TO OBTAIN A PAPER COPY OF THIS NOTICE

You have the right to obtain a paper copy of this notice upon request, even if you have agreed to receive the Notice electronically.

WHAT IF I HAVE A COMPLAINT?

If you believe that your privacy has been violated, you may file a complaint with us or with the Secretary of Health and Human Services in Washington, D.C. We will not retaliate or penalize you for filing a complaint with us or the Secretary.

- To file a complaint with us, please contact our Risk Management Department or call the UHS Compliance Hotline at **1-800-852-3449**. Your complaint should provide specific details to help us in investigating a potential problem.
- To file a complaint with the Secretary of Health and Human Services, write to: 200 Independence Ave., S.E., Washington, D.C. 20201 or call **1-877-696-6775.**

CONTACT FOR ADDITIONAL INFORMATION

If you have questions about this Notice or need additional information, you can contact our Risk Management Department (or the UHS Compliance Hotline at 1-800-852-3449).

SOME OF OUR PRIVACY OBLIGATIONS AND HOW WE FULFILL THEM

Federal health information privacy rules require us to give you notice of our legal duties and privacy practices with respect to PHI and to notify you following a breach of unsecured PHI. This document is our notice. We will abide by the privacy practices set forth in this notice. We are required to abide by the terms of the notice currently in effect. However, we reserve the right to change this notice and our privacy practices when permitted or as required by law. If we change our notice of privacy practices, we will provide you with a copy to take with you upon request and we will post the new notice.

COMPLIANCE WITH CERTAIN STATE LAWS

When we use or disclose your PHI as described in this notice, or when you exercise certain of your rights set forth in this notice, we may apply state laws about the confidentiality of health information in place of federal privacy regulations. We do this when these state laws provide you with greater rights or protection for your PHI. For example, some state laws dealing with mental health records may require your express consent before your PHI could be disclosed in response to a subpoena. Another state law prohibits us from disclosing a copy of your record to you until you have been discharged from our hospital. When state laws are not in conflict or if these laws do not offer you better rights or more protection, we will continue to protect your privacy by applying the federal regulations.

Effective Date: This notice takes effect on September 23, 2013 Version # 1

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