MONTROSE
MEMORIAL HOSPITAL
800 South Third Street
Montrose, CO 81401-4291
970-249-2211
MontroseHospital.com

Notice of Information Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This notice describes Montrose Memorial Hospital's privacy practices and that of: °Any healthcare professional authorized to enter information into your hospital record. °All departments and units of the hospital. ° Any member of a volunteer group we allow to help you while you are in the hospital. ° All employees, staff and other hospital personnel. ° All managed and affiliated sites of Montrose Memorial Hospital will follow the terms of this notice. All these locations may share medical information with each other for treatment, payment, or hospital operations purposes described in this notice.

OUR PLEDGE REGARDING MEDICAL INFORMATION: We understand that protected health information (PHI) about you and your health is personal. We are committed to protecting your PHI. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by our organization, whether made by hospital personnel or your provider. Your provider may have different policies or notices regarding the provider's use and disclosure of your PHI created in the provider's office or clinic. This notice will tell you about the ways in which we may use and disclose your PHI. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information. We are required by law to: °make sure that PHI that identifies you are kept private; °give you notice of our legal duties and privacy practices with respect to PHI about you; ° follow the terms of the notice that is currently in effect; ° notify you if we are unable to agree to a requested restriction; ° accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations. We reserve the right to change our practices and make the new provisions effective for all PHI we maintain. Should our information practices change, we will make available to you a revised notice. We will not use or disclose your health information without your authorization, except as described in this notice.

HOW WE MAY USE AND DISCLOSE INFORMATION ABOUT YOU: The following categories describe different ways that we use and disclose PHI. For each category of use and disclosure we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories. ° **FOR TREATMENT:** We may use PHI about you to provide you with medical treatment or services. We may disclose PHI about you to doctors, nurses, technicians, medical and nursing students, or other hospital personnel who are involved in taking care of you at the hospital. For example, a physician treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. In addition, the physician may need to tell the dietitian if you have diabetes so that we can arrange for appropriate meals. Other departments of the hospital also share information about you in order to coordinate the different services you need, such as medications, lab work and x-rays. We also disclose information about you to people outside the hospital who may be involved in your care after you leave the hospital, such as family members, or others who may provide services that are part of your care. We also provide your physician or subsequent healthcare providers with copies of various reports that assist in treating you once you're discharged from the hospital. These reports may be provided through the Quality Health Network. ° **FOR PAYMENT:** We may use and disclose PHI about you so that the treatment and services you receive at the hospital may be billed to and payment may be collected from you, an insurance company or third party. For example, we may need to give your health plan information about surgery you received at our hospital so your health plan will pay us or reimburse you for the surgery. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment. ° **FOR HEALTHCARE OPERATIONS:** We may use and disclose PHI about you for hospital operations. These uses and disclosures are necessary to our organization and make sure that all our patients receive quality care. For example, we may use PHI to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also use PHI about many hospital patients to decide what additional services the hospital should offer, what services are not needed, and whether certain new treatments are effective. We may also disclose information to physicians, students and staff for learning purposes. We may also compare information with other hospitals to perform comparative analysis and identify improvement opportunities. We may remove information that identifies you from this set of PHI so others may use it to study healthcare without learning who the specific patients are.

FUNDRAISING ACTIVITIES: We may use certain information (name, address, telephone number or e-mail information, age, date of birth, gender, health insurance status, dates of service, department of service information, treating physician information or outcome information) to contact you for the purpose of raising money for Montrose Memorial Hospital and you will have the right to opt out of receiving such communications with each solicitation. Your decision to opt out will have no impact on your treatment or payment for services. **HOSPITAL DIRECTORY:** If you do not object, we may include certain limited information about you in the hospital directory while you are a patient in the hospital. This information may include your name, location in the hospital, your general condition (e.g. fair, stable, etc.) and your religious affiliation. The directory information, except your religious affiliation, may also be released to people who ask for you by name. Your religious affiliation and general information about the reason you are here may be given to a member of the clergy, even if they don't ask for you by name, to assist with your spiritual needs. In an emergency or when you are not capable of agreeing or objecting to these disclosures, we will disclose PHI and what we determine is in your best interest, but will tell you about it later, after the emergency, and give you an opportunity to object to future disclosures to family and friends.. Unless you object, we may also disclose your PHI to persons performing disaster relief notification activities. **INDIVIDUALS INVOLVED IN YOUR CARE OR PAYMENT FOR YOUR CARE:** We may release medical information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. In the event of a disaster, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location. **RESEARCH:** We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information. **AS REQUIRED BY LAW:** We disclose medical information about you when required to do so by federal, state or local laws. **PUBLIC HEALTH RISKS:** We may disclose medical information about you for public health activities. These activities generally include the following: to prevent or control disease, injury or disability; to report births and deaths; to report reactions to medications or problems with products; to notify people of recalls of products they may be using; to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence. **LAWSUITS AND DISPUTES:** If you are involved in a lawsuit or dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order to protect the information requested. **LAW ENFORCEMENT:** We may release medical information if asked to do so by a law enforcement official: In response to a court order, subpoena, warrant, summons, or similar process; to identify or locate a suspected fugitive, material witness or missing person; about the victim of a crime, if under certain limited circumstances, we are unable to obtain the person's agreement; about a death we believe may be the result of criminal conduct; about

criminal conduct at the hospital and in emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime. **CORONERS, MEDICAL EXAMINERS AND FUNERAL DIRECTORS; ORGAN PROCUREMENT**: We may release medical information to a coroner, medical examiner or organ procurement organization. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about the deceased to funeral directors, as necessary, to carry out their duties. **INMATES:** If you are an inmate of a correctional institution or under custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with healthcare; (2) to protect your health and the safety and health of others; (3) for the safety and security of the correctional institution. **BUSINESS ASSOCIATES:** There are some services provided in our organization through contacts with business associates. Examples include oxygen vendors, a copy service we use when making copies of your medical record, or an outside laboratory analysis. When these services are contracted, we may disclose your health information so that they can perform the job we've asked them to do, and bill you or your third party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU: You have the following rights regarding medical information we maintain about you: **RIGHT TO INSPECT AND COPY:** You have the right to inspect and receive a paper or electronic copy of medical information that may be used to make decisions about your care. Usually this includes medical and billing records but does not include psychotherapy notes. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the Health Information Management Department. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by the hospital will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review. **RIGHT TO AMEND:** If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the hospital. To request an amendment, your request must be made in writing and submitted to the Privacy Officer. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing, or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that: was not created by us, unless the person or entity that created the information is no longer available to make the amendment; is not part of the medical information kept by or for the hospital; is not part of the information which you would be permitted to inspect and copy; or is accurate and complete. **RIGHT TO AN ACCOUNTING OF DISCLOSURES:** You have a right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you. It will not include disclosures we have made for treatment, payment and healthcare operations, nor those made to your friends or family through our facility directory, or for disaster notification purposes. To request this accounting, you must submit your request in writing to the hospital's Privacy Officer. Your request must state a time period, which may not be longer than six years and may not include dates before April 21, 2003. Your request should indicate in what form you want the list (paper or electronic). The first list you request within a 12 month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred. **RIGHT TO REVOKE:** You have the right to revoke your authorization to use or disclose health information except to the extent that action has already been taken. **RIGHT TO REQUEST RESTRICITONS:** You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or healthcare operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment of your care, like a family member or friend. *We are not required to agree with your request.* If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions you must make your request in writing to the Privacy Officer. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply. If you pay for services out of pocket in full, you may ask us to not share that information for payment purposes with your health insurer. **RIGHT TO REQUEST CONFIDENTIAL COMMUNICATION:** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. To request confidential communications, you must make your request in writing to the Privacy Officer. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted. **RIGHT TO A PAPER COPY OF THIS NOTICE:** You will be offered a paper copy of this notice. You may ask us to give you a copy of this notice at any time. To obtain a copy of this notice, please see the Admissions Department. The hospital personnel who offers the notice shall make a good faith effort to obtain acknowledgment when the notice was accepted by the individual or by his/her representative. If acknowledgment cannot be obtained despite a good faith effort, the hospital personnel shall document the attempt and the reason for failure to obtain the acknowledgment. In an emergency situation, the hospital personnel need not attempt to obtain acknowledgment of an individual until it is practicable to do so. The notice shall be made available to any person upon request. For this purpose, a supply of this noticed shall be kept in Admissions, ED Admissions electronically. Individuals requesting a copy of this notice shall be directed to one of those areas or to the Privacy Officer. Whenever there is a material change to the uses or disclosures, individual's rights, or the hospital's legal duties with respect to privacy of PHI or its other privacy practices, the notice shall be promptly revised, and the revised notice made available. A new acknowledgment is not required for providing a revised notice. No material change in any term of the notice may be implemented prior to the effective date of the revised notice in which the change is reflected, unless the change is required by law. Each revised notice shall include the month and year on which the revised notice becomes effective. **COMPLAINTS:** If you believe your privacy rights have been violated you may file a complaint with the hospital or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing to the Privacy Officer. **You will not be penalized for filing a complaint. OTHER USES OF MEDICAL INFORMATION:** Other uses and disclosures of medical information not covered by this notice or laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission in writing at any time. If you revoke your permission we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to reverse any disclosures we have already made with your permission or for treatment, payment or our healthcare operations, and that we are required to retain our records of the care that we provided to you.

If you have any questions about this notice, please contact our Privacy Officer at 240-7368. Version 8 6/22/16

ALPINE WOMEN'S CENTRE

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF INFORMATION PRACTICES

_____

Patient Last Name Patient First Name Date of Birth

By signing below, I am acknowledging that I have received a copy of the Notice of Information Practices and I understand that I may contact the person named in the Notice if I have questions about the content of the Notice.

_____

Signature of patient/parent/legal guardian/patient representative Date

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To be completed by staff if patient/personal representative does not sign acknowledgement above or below

____ Patient/personal representative refused to sign form

____ Other reason for not signing _____

_____

_____

Signature of Staff Member Date

AVISO DE PROCEDIMIENTOS DE PRIVACIDAD

_____

Nombre de Paciente Fecha de Nacimiento

A firmar abajo, estoy reconociendo que he rescibido una copia del aviso de procedimientos de privacidad y entiendo que puedo contractar con a la persona indicada en el viso si tengo preguntas sobre el conntiendo de la notificacion.

_____

Firma del paciente/padre/guarda legal/paciente responsible Fecha

ALPINE WOMEN'S CENTRE
MONTROSE MEMORIAL HOSPITAL
715 S. Third Street, Montrose, CO 81401

PATIENT FINANCIAL AGREEMENT

Payment Agreement

I, whether I sign as guardian, representative or as the patient, assume full responsibility for and agree to pay in accordance with this agreement all costs, charges and expenses for services provided by Alpine Women's Centre at Montrose Memorial Hospital. I understand that my insurance may or may not consider Alpine's providers "in-network" and that I am ultimately responsible for all charges. It is my responsibility to provide a current insurance card at the time of my visit and to verify that my insurance coverage is still active. In the event my insurance company determines that a service is "not covered", I am responsible for the unpaid portion.

I understand that these charges may not include the hospital, radiologist(s), pathologist(s), or anesthesiologist(s) fee. I hereby agree to pay all costs and fees, including reasonable attorney fees, in the event Alpine Women's Centre at Montrose Memorial Hospital brings an action because of my failure to pay all bills.

I understand that I must pay any balances due in a timely manner and co-payments at the time of service. If my insurance eligibility is not able to be verified, I must pay the amount in full or contact the billing department of Alpine Women's Center at 970-249-6737 ext. 23 or 13 in advance of my appointment to make payment arrangements. Alpine's billing department is also available to me to answer questions regarding my account and my insurance claims. If I am uninsured, Alpine's billing department will work with me on a payment plan. I will receive monthly statements which will indicate the balance due and payments made to each claim.

Furthermore, I understand that if I fail to show up for my appointment or fail to cancel 24 hours in advance, I may be charged $30.00 for physician care planning as part of the preparation for my appointment.

If I fail to respond to collection requests or fail to make payments as agreed, I understand that Alpine's billing department has an obligation to turn my account over to a collection agency. I will pay all court costs, collections fees and interest at the rate of 21% APR on my balance. If I write a check that is returned by the bank, I understand that I may be responsible for any bank fees incurred.

Waiver of Responsibility for Personal Valuables

Alpine Women's Centre at Montrose Memorial Hospital will not be responsible for any loss, theft or damage to any o**f** my personal property as a Patient (including money, jewelry, documents, clothing, eyeglasses, and other personal articles).

Authorization for Release of Information: I authorize Alpine Women's Centre at Montrose Memorial Hospital to release information to my insurance company for the purpose of obtaining payment for medical services received. If my insurance company denies a claim after it is billed, I will pay the balance in full and settle all disputes with my insurance company.

Assignment of Benefits

I hereby assign all medical and surgical benefits to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s) including Medicare, private insurance and any other health/medical plan to issue payment check(s) directly to Alpine Women's Centre at Montrose Memorial Hospital for medical services rendered to me and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

The Undersigned hereby certifies that he/she has read this financial agreement and that it has been fully explained and that he/she understands its contents.

Patient Name - Printed	Person Authorized to Sign for Patient
Patient or Authorized Person's Signature	Date

Rev. 03/ 2018

ALPINE WOMEN'S CENTRE
MONTROSE MEMORIAL HOSPITAL

HEALTH SUMMARY UPDATE FORM

NAME: _____ ***DOB***: ____/_____/_____ ***DATE***: ____/____/____

Current Medications/Supplements (and Dosage) **N/A_____

_____ _____ _____ _____ _____
_____ _____ _____ _____ _____

Current Allergies (Drug/Environmental) **N/A_____

_____ _____ _____ _____ _____

Current Social History Do you drink alcohol? Yes ___ / No _____ //// _____ per day ___/week____
Do you smoke? Yes___ / No ____ // ____pack(s) per day for ____ year(s) What year did you quit? _____
Have you used street drugs within the past 5 years? Yes___ / No ____

Current Personal Health History Please circle all that apply. **N/A_____

Hot Flashes Sleep Disturbance Stroke Seizure Headaches Anxiety Depression High Blood Pressure High Cholesterol Ulcer Anemia Liver Disease Colitis Blood in Stool Gallstones Kidney Disease Kidney Stones Heart Attack Heart Murmur Palpitations Blood Clot Lupus Asthma Emphysema Bronchitis Tuberculosis Skin Disease Arthritis Scoliosis Osteoporosis Osteopenia Diabetes Thyroid Disease Abuse (type) _____ Cancer (type) _____

Gynecologic History
Are you currently sexually active? _____ If so, how long have you been with the same partner? _____
Date of last Pap smear____/____ Abnormal Pap smear? _____ If so, what year? _____
Date of last mammogram____/____ Date of last colonoscopy (over age 50) _____/_____
Do you perform routine self-breast exam? _____
First Day of Last Menstrual Period ____/____/____ Age at first period _____
Do you have/have you had a sexually transmitted disease?_____
Birth control: Pills/NEX/IUD?_____ Tubal Ligation?_____ Vasectomy?____

In the last year, have you been pregnant or had a baby? **N/A_____ Currently pregnant? _____

Vag/C-Sect, miscarr, abort	Complications	Physician
_____	_____	_____
_____	_____	_____
_____	_____	_____

In the last year, have you had a surgery? **N/A_____

Year	Surgery	Surgeon
____	_____	_____
____	_____	_____
____	_____	_____

In the last year, have you been hospitalized (other than for surgery)? **N/A_____

Year	Reason	Location
____	_____	_____
____	_____	_____

In the last year, has anyone in your family been diagnosed with breast, ovarian or colon cancer?

Condition/Family Member	Condition/Family Member
_____	_____
_____	_____

ALPINE WOMEN'S CENTRE
MONTROSE MEMORIAL HOSPITAL

715 South 3rd St.
Montrose, CO 81401
Phone 970.249.6737
Fax 970.252.0112

Richard G. Hanley, M.D., F.A.C.O.G James N. Gilham, D.O., F.A.C.O.G
Derick A. Fenton, M.D., F.A.C.O.G Meg Benasutti, A.N.P. Sheena Wisler, M.D.

ATTN: Patient

RE: Rx for Controlled Drug

If you receive a prescription for a "controlled" (Schedule II through V) drug, your identifying prescription information will be entered into Colorado's Prescription Drug Monitoring Program database (PDMP) when this drug is dispensed to you. Your prescription information in the database is a protected health record and cannot be accessed by non-caregivers except as part of an authorized investigation. You have the right to access your information in the PDMP through the Colorado Board of Pharmacy. You may seek corrections to the information as you would your other medical records.