THE LUSKIN
Orthopaedic Institute for Children
IN ALLIANCE WITH UCLA Health

Expert Orthopaedic Care For All Children Since 1911
403 West Adams Boulevard, Los Angeles, CA 90007-2664

Urgent Care Center Registration Form

Patient Information

Last Name	First Name	DOB Month / Day / Year	Sex ☐Female ☐Male
Home Address	City	Race ☐American Indian or Alaska Native ☐Asian ☐Black or African American ☐Native Hawaiian or Other Pacific Islander ☐White ☐Other ☐I decline to self-identify	Ethnicity ☐Hispanic or Latino ☐Not Hispanic or Latino
State	Zip Code	Occupation	Social Security Number – –
School Patient Attends		Reason For Visit	

Parent/Guardian (with ID)

Last Name	First Name	DOB Month / Day / Year	
Relationship to Patient	Mother's Maiden Name		
Home Address (if different from above)	City	State	Zip Code
Mobile Phone	Home Phone		Language Preference
Are you the legal guardian? ☐Yes ☐No	Email		

Primary Care Physician

Physician Last Name	Physician First Name		
Address	City	State	Zip Code
Do we have your authorization to release information to your Primary Care Physician? ☐Yes ☐No	Primary Care Physician's Phone Number:		
Who directed you to OIC Urgent Care?	Would you like to receive appointment reminders? ☐Yes ☐No If yes, choose one: ☐Text ☐Automated Voice Reminders		

Emergency Contact (other than yourself)

Last Name	First Name	Relationship to Patient
Mobile Phone Number	Home Phone Number	

Please include your ID, insurance card and referral if available.
Patients should not eat or drink prior to seeing medical staff. _____ Initial here

Time In:

MRN:

Patient Name:

DISCLOSURE & CONSENT

CONSENT TO TREATMENT. By signing below, I (or my authorized representative on my behalf) authorize OIC staff to conduct medically indicated diagnostic examinations, tests and non-invasive procedures and to provide any medications, treatment or therapy necessary to effectively assess and maintain my health, and to assess, diagnose and treat my illness or injuries. I understand that it is the responsibility of my individual treatment healthcare providers to explain to me the reasons for any particular diagnostic examination, test or procedure; the available treatment options and the common risks and anticipated burdens associated with these options and the common risks and anticipated burdens and benefits associated with these options as well as alternative courses of treatment.

RIGHT TO REFUSE TREATMENT. In giving my general consent to treatment, I understand that I retain the right to refuse any particular examination, test, procedure, treatment, therapy or medication recommended or deemed medically necessary by my individual treating health care providers. I also understand that the practice of medicine is not an exact science and that no guarantees have been made to me as to the results of my evaluation and/or treatment.

PHYSICIAN EXTENDERS. Undersigned is informed and agrees that qualified medical practitioners, including, but not limited to, Nurse Practitioners and Resident Physicians, may perform important parts of patients' care that are within their scope of practice as determined by state law, for which they have been granted privileges by the Institute. The undersigned may refuse care from physician extenders by initialing here _____, or requesting physician services at any time during treatment, and agrees that patient may be redirected or subject to a longer wait time for treatment outside of usual procedures.

VIDEO VISITS. Video Visits involve the use of secure audio-visual connection to enable a healthcare provider and a patient at different locations to communicate and share individual patient health information for the purpose of rendering clinical care.

I understand that during my care at OIC, I may be offered a Video Visit if clinically appropriate. These services may include consultation, diagnosis, treatment recommendation, prescriptions, and/or referral to in-person care if further evaluation is needed. This service is offered to me as a convenience. I understand that I always maintain the option of choosing an in-person appointment if I prefer. I understand that not all services will be clinically appropriate to complete via a video visit and the option will be limited by my provider's discretion. I understand that some parts of the services (e.g., labs, bloodwork, or scans) may be ordered during the visit, which would require me to go in-person to a facility.

Should I agree to a Video Visit, I consent to have my insurance billed for the services and will pay any relevant copays and/or coinsurances.

I understand that during the Video Visit, sensitive medical information may be discussed, and it will be my responsibility to locate myself in a location that ensures privacy to my own level of comfort. I will also be expected to participate in a location that will not cause danger to myself or those around me (such as while driving). If my provider is concerned about my safety, they may terminate the visit.

Video Visits are not appropriate for medical emergencies. If I believe I am having an emergency, I will call 911 and/or go to my nearest emergency room.

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DISCLOSURE & CONSENT

TEACHING FACILITY. The Institute serves as a teaching facility. Observers, such trainers, as medical device specialists, health care professionals or students, will introduce themselves and request your permission to observe care. You may proactively decline at any time during your treatment.

RELATED INTERESTS. Undersigned agrees that patient is not required to obtain items/services from any of the following departments of the Institute. If you choose, or as a requirement of your insurance plan, the Institute will provide the information for you to seek non-urgent items/services from another provider. The Institute has an interest in the Orthopaedic Hospital Outpatient Pharmacy, Physical Therapy Department, Radiology Department, and Laboratory.

RELEASE OF INFORMATION. The undersigned grant(s) authority to the Orthopaedic Institute for Children/OHTC, members of the clinical staff, and employees, to give information regarding any or all medical records of the patient to all HIPAA covered entities involved in the patient's treatment, billing for that treatment and healthcare operations.

The undersigned may restrict release of information to specified parties, or for specific services, by indicating restrictions in writing to the Information Security Officer per Privacy Practices notice. Undersigned has received a copy of the Institute's Privacy Practices.

PHONE CONTACT. Undersigned agrees Institute may contact patient and leave a voice message regarding appointment reminders. Appointment reminders contain the patient's name, the name of clinic appointment, time and date. You agree to keep the Institute informed of up-to-date phone contact preferences.

PERSONAL VALUABLES. It is agreed that the Institute is not liable for the loss or damage to any money, jewelry, documents, or other articles of value lost or damaged on the premises.

AUTHORIZATION FOR SIGNATURE BY EITHER PARENT. I (We) and each of use hereby agree(s) that all authorizations and consents that hereafter may be required by Orthopaedic Institute for Children to the above mentioned and to any and all other acts or procedures, including subsequent re-admissions and discharges from time to time from Orthopaedic Institute for Children:

☐ May be executed by either one of the undersigned parents acting alone, and the father hereby appoints the mother and the mother hereby appoints the father, as his or her attorney-in-fact, with full powers to execute any and all such authorizations and consents, acting in his or her own name and also the name of the other.

☐ May only be authorized by the undersigned.

REVOCATION. All consents, authorities, and agreements in this document shall continue and remain in full force and in effect for the next 12 months, unless undersigned provides written notice of revocation to the Institute's Security Officer.

FINANCIAL AGREEMENT. The undersigned agree(s), whether s/he signs as agent, parent, or a patient, that in consideration of the services to be rendered to the patient, s/he agrees to assist the Institute in receiving prompt payment of the charges, and pay the account of the Institute in accordance with the patient's coverage or lack thereof. Should the account be referred to an

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Patient Name:

DISCLOSURE & CONSENT

attorney for collection, the undersigned shall pay reasonable attorneys and collection expense. All delinquent accounts bear interest at the legal rate.

OPEN PAYMENTS DATABASE. The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found here (https://openpaymentsdata.cms.gov/). For informational purposes only, a link to the federal Centers for Medicare and Medicaid Services (CMS) Open Payments web page is provided here. The federal Physician Payments Sunshine Act requires that detailed information about payment and other payments of value worth over ten dollars ($10) from manufacturers of drugs, medical devices, and biologics to physicians and teaching hospitals be made available to the public.

NOTICE OF PRIVACY PRACTICES. The undersigned acknowledges that the Institute has provided a Notice of Privacy Practices effective 9/19/2013.

THE UNDERSIGNED CERTIFIES THAT S/HE HAS READ THIS DOCUMENT, RECEIVED A COPY, AND IS THE PATIENT, OR HAS THE AUTHORITY TO EXECUTE THIS AGREEMENT AND ACCEPT ITS TERMS ON BEHALF OF THE PATIENT.

_____ _____ _____

Patient/Parent/Guardian Signature Date Time

If other than patient, indicate relationship _____

_____ _____ _____

Orthopaedic Institute for Children by its duly authorized representative Date Time

☐ Please send me email communication on health topics of interest to me/my child:
E-mail address: _____

☐ The Los Angeles Orthopaedic Foundation may send me information on future events.

MRN:
Patient Name:

(Patient Label)

NOTICE OF PRIVACY PRACTICES

Effective Date: September 23, 2013

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.

If you have any questions about this notice, please contact Medical Records Privacy Officer at (213) 741-8380.

OUR OBLIGATIONS

We are required by law to:

- Maintain the privacy of protected health information
- Give you this notice of our legal duties and privacy practices regarding health information about you
- Follow the terms of our notice that is currently in effect

Patient records created by Orthopaedic Institute for Children

I. are integrated into the UCLA Health electronic health record (EHR);
II. will be accessible by UCLA Health and/or its affiliates; and
III. may be used by UCLA Health for quality, maintenance and operations of the EHR, and for treatment and research purposes in accordance with law.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION

The following describes the ways we may use and disclose health information that identifies you ("Health Information'}. Except for the purposes described below, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our practice Privacy Officer.

For Treatment. We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors. nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

For Payment. We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company or a third party for the treatment and services you received. For example, we may give your health plan information about you so that they will pay for your treatment.

For Health Care Operations. We may use and disclose Health Information for health care operations purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the obstetrical or gynecological care you receive is of the highest quality. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

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Appointment Reminders, Sign In* Sheets, *Public Address system, Treatment Alternatives and Health Related Benefits and Services. We may use and disclose Health Information to contact you to remind you that you have an appointment with us. We may use a sign in sheet containing your name only. We may call your name only on the public address system. We also may use and disclose Health Information to tell you about treatment alternatives or health- related benefits and services that may be of interest to you.

Photography. We may release photographs or video of a procedure/treatment for medical, scientific or educational purposes. Upon participation in Medical Center's community events, we may release patients' general image by any media.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as a parent regarding the care of a minor, or family/friends as indicated on the consent and disclosure form. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research. Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be asked to participate in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

SPECIAL SITUATIONS

As Required by Law. We will disclose Health Information when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Military and Veterans. If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

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Workers' Compensation. We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks*.* We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; State Immunization Registry; National Institutes for Health Surveillance, Controlled Substance Pharmacy Reporting, and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities*.* We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include. for example, audits. investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Data Breach Notification Purposes. We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We also may disclose Health Information 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 protecting the information requested.

Law Enforcement. We may release Health Information if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

National Security and Intelligence Activities. We may release Health Information to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.

Protective Services for the President and Others. We may disclose Health Information to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or to conduct special investigations.

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Inmates or Individuals in Custody. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be if necessary: (1) for the institution to provide you with health care: (2) to protect your health and safety or the health and safety of others: or (3) the safety and security of the correctional institution.

USES AND DISCLOSURES THAT REQUIRE US TO GIVE YOU AN OPPORTUNITY TO OBJECT AND OPT OUT

Individuals Involved in Your Care or Payment for Your Care. Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your Protected Health Information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

Disaster Relief. We may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practically can do so.

YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES

The following uses and disclosures of your Protected Health Information will be made only with your written authorization:

- Uses and disclosures of Protected Health Information for marketing purposes; and
- Disclosures that constitute a sale of your Protected Health Information
- Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose Protected Health Information under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

YOUR RIGHTS

You have the following rights regarding Health Information we have about you:

Right to Inspect and Copy. You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing, to the Medical Records Privacy Officer 213-741-8380. We have up to 30 days to make your Protected Health Information available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social

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Security Act or any other state of federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.

Right to an Electronic Copy of Electronic Medical Records. If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your Protected Health Information in the form or format you request, if it is readily producible in such form or format. If the Protected Health Information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

Right to Get Notice of a Breach. You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

Right to Amend. If you feel that Health Information, we have 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 our office. To request an amendment, you must make your request, in writing, to the Medical Records Privacy Officer, (213) 741- 8380.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to the Medical Records Privacy Officer (213) 741-8380.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to the Medical Records Privacy Officer 213-741-8380. We are not required to agree to your request unless you are asking us to restrict the use and disclosure of your Protected Health Information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us "out-of-pocket" in full. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

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Patient Name:

(Patient Label)

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Out-of-Pocket-Payments. If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. To request confidential communications, you must make your request, in writing, to the Medical Records Privacy Officer 213-741-8380. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our web site, www.ortho-institute.org. To obtain a paper copy of this notice, please contact the Medical Records Privacy Officer at 213-741-8380, providing your mailing address.

CHANGES TO THIS NOTICE

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact:

Natalie Anthony, RN
Orthopaedic Institute for Children
403 West Adams Boulevard
Los Angeles, CA 90007
Phone: (213) 741-8379 | Email: oicpatientrelations@mednet.ucla.edu

All complaints must be made in writing. **You will not be penalized for filing a complaint.**

MRN:
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(Patient Label)

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I acknowledge that I have received the Notice of Privacy Practices.

_____ _____ _____
Signature of Patient or Patient's Representative Date Time

_____ _____
Print Name Relationship to Patient

_____ _____
Interpreter (if applicable) Interpreter ID #

COMPLETE IF WRITTEN ACKNOWLEDGMENT WAS NOT OBTAINED
Please document your efforts to obtain acknowledgment and reason it was not obtained (please initial).

1. _____ Notice of Privacy Practices Given – Patient Unable to Sign

2. _____ Notice of Privacy Practices Given – Patient Declined to Sign

3. _____ Notice of Privacy Practices and Acknowledgment Mailed to Patient

Other Reason Patient Did Not Sign: _____

THE LUSKIN Orthopaedic Institute for Children IN ALLIANCE WITH UCLA Health

MRN:

Patient Name:

SPORTS REFERRAL PROGRAM
(Children Playing a Sport at School – High School)

1. What school does your child go to?

   School Name: _____

   City and Zip: _____

2. What sport(s) does your child play?

   _____

3. Do you know if there is an athletic trainer at your child's school or organization?

   ☐ Yes ☐ No ☐ I don't know

4. If your child has an athletic trainer for their sport, may we contact the Athletic Trainer and give medical information to have them assist with your child's care after our treatment?

   ☐ Yes ☐ No

_____ _____ _____

Patient or Representative Signature | Date | Time

If signed by someone other than the patient, please specify relationship to patient: _____

_____ _____ _____

Interpreter Signature | Date | Time

Interpreter ID # _____