USC HEALTHCARE REGISTRATION FORM

PATIENT INFORMATION

Legal Last Name	First	MI	AKA Name	Patient MRN-Office Use Only

Social Security	Sex	Birth Date / /	Marital Status S M W D	Drivers License

Residence Street Address	Apt	City	State	Zip	Country

Day Phone ( )	Evening Phone ( )	Pager ( )	Cell Phone ( )

Employer's Name	Address	City	State	Zip	Country	Occupation

Race	Religious Preference	Place of Birth	Email

Referring Physician	Referring Physician Street Address	Suite	City	State	Zip	Phone

PERSON TO CONTACT IN CASE OF EMERGENCY

Last Name	First	MI	Relationship

Residence Street	Apt	City	State	Home Phone ( )	Business Phone Ext ( )

Nearest Relative or Friend not living with You	Last Name	First	MI	Relationship

Residence Street	Apt	City	State	Home Phone ( )	Business Phone Ext ( )

GUARANTOR (PERSON WHO GUARANTEES FINANCIAL OBLIGATION)

Last Name	First	MI	Relationship	Social Security	Driver's Lic No

Residence Street	Apt	City	State	Zip	Country	Evening Phone ( )

Employer's Name	Address	City	State	Work Phone ( )	Occupation

INSURANCE INFORMATION

PRIMARY INSURANCE	Subscriber's Name	Relationship	Subscriber's Residence Street (if not the same as patient)	Apt	City	State	Zip

Subscriber's SSN	Subscriber's DOB	Employer Name and Address	Employer's Phone Number ( )	Ext

Insurance Company Name	Policy, Cert, Badge, Medicare or Medi-Cal #	Plan	Group No

Insurance Mailing Address	Insurance Co Phone ( )

Medical Group Name or IPA	Medical Group Phone Number ( )	Effective Date

SECONDARY INSURANCE	Subscriber's Name	Relationship	Subscriber's Residence Street (if not the same as patient)	Apt	City	State	Zip

Subscriber's SSN	Subscriber's DOB	Employer Name and Address	Employer's Phone Number ( )	Ext

Insurance Company Name	Policy, Cert, Badge, Medicare or Medi-Cal #	Plan	Group No

Insurance Mailing Address	Insurance Co Phone ( )

Medical Group Name or IPA	Medical Group Phone Number ( )	Effective Date

Assignment of Benefits: I hereby authorize the doctors of USC Healthcare to furnish information to insurance carriers. I hereby irrevocably assign to the doctors of USC Healthcare all payments for services rendered and all major medical benefits.
Consent for Treatment: I hereby authorize my consent to be treated now and in the future by the doctors of USC Healthcare.

______________________________ Signature of Patient/Insured

______________________________ Date

Office Use Only	Documents scanned: ☐ ID Card ☐ Ins Card ☐ Referral	Name:	Ext:

Form 1-3 (Rev. 3/04)

USC OCCUPATIONAL THERAPY FACULTY PRACTICE
1640 Marengo Street, Suite 500 ◆ Los Angeles, CA 90033
T: (323) 442-3340 F: (323) 442- 3351

Consent for Delivery of Services:

This is an occupational therapy program provided on an outpatient basis. This program is not intended as a substitute for expert medical advice you have received from other health professionals. Any application of the health recommendations set forth by this program is at the participants' discretion and sole risk.

This information is intended to be used only as a guideline for healthy eating, and is not meant to be a substitute for a medically prescribed diet. If you are currently on a medically prescribed diet or have any specific medical conditions that require you to be on one, please consult your physician. In addition, please use your discretion regarding food allergies and intolerances. Although there are a variety of foods included within the program, it is not recommended that you consume any foods you are allergic or intolerant to.

The information from this program is intended to be used only as a guideline for healthy living. If you have specific medical conditions, please consult with your physician.

My enrollment in this program is solely on a volunteer basis.

I understand that OT visits may be shared with another healthcare service such as PT or chiropractic and it is my responsibility to be aware of my benefits.

Protecting your privacy is extremely important to us. In exchange for your trust, we promise to observe the following principles: We will ask only for the information we need in order to provide the highest level of service to you. We will not release personal identifying information about you without your consent. *We also ask that all information shared within group sessions, as well as the identities of those within the group sessions remain confidential.*

Initial: ___________

Payment Consent:

All clients must make any required co-payments or other fees at the time of service. Please make all checks payable to the *USC Care Medical Group*. We do not accept American Express. If your session did not occur in-person, please call the front desk to provide your payment over the phone.

Initial: ___________

USC Students: (IF NOT APPLICABLE, PLEASE SKIP TO SIGNATURE ON SECOND PAGE)

If you are a USC student, please answer the following questions:

- Which academic department is your program in? ____
- Which USC health center are you registered with? ☐ HSC ☐ UPC
- Are you registered at USC with a disability? ☐ Yes ☐ No

Initial: ___________

(Turn page over)

Cancellation Policy

In our programs, consistent attendance is vital because it:

- Provides accountability needed for behavior change
- Facilitates progress towards long-term goals
- Ensures commitment to action plans by the OT and participant

If you must cancel an appointment, we ask that you **call us immediately** (323-442-3340), or **at least 24 hours in advance** of your originally scheduled appointment, so that we may accommodate other patients. We also ask that you **arrive on-time** to all scheduled appointments, to optimize treatment at each session.

Failure to cancel an appointment more than 24 hours in advance will result in a **$25 late-cancel/no-show fee**, which is not covered by insurance. For appointments scheduled on a Monday, please call by the Friday prior to the appointment to avoid a fee.

Individuals who violate this policy **(cancel less than 24 hours in advance, or no-show) three times will no longer be eligible** to schedule appointments in advance, and will need to call same-day to schedule if openings are available.

Patient Initial: ___________ **Reception Initial: ___________** **Therapist Initial: ___________**

Agreement:

I have read (or someone has read to me) and I understand the information provided above. I have been given the opportunity to ask questions and all of my questions have been answered to my satisfaction. My signature below indicates that I agree to participate in this program.

Please print and sign below.

____ _______________________________

NAME OF PATIENT (PRINT) DATE

____

SIGNATURE OF PATIENT

____

SIGNATURE OF GUARDIAN

UNIVERSITY OF SOUTHERN CALIFORNIA
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

What is this Notice and Why Is It Important?

By law, the University of Southern California (USC)[1] must protect the privacy of your identifiable medical and other health information ("health information").

USC also is required by law to give you this notice to tell you how we may use and give out ("disclose") your health information. USC must follow the terms of this notice when using or disclosing your health information.

This notice is effective as of April 1, 2018.

How USC May Use Your Health Information

As a general rule, you must give written permission before USC can use or release your health information. There are certain situations where USC is not required to obtain your permission. This section explains those situations where USC may use or disclose your health information without your permission.

Except with respect to Highly Confidential Information (described below), USC is permitted to use your health information for the following purposes:

- **Treatment:** We use and disclose your health information to provide you with medical treatment or services. This includes uses and disclosures to:
  - treat your illness or injury, including disclosures to other doctors, practitioners, nurses, technicians or medical personnel involved in your treatment, or
  - contact you to provide appointment reminders, or
  - give you information about treatment options or other health related benefits and services that may interest you.

- **Payment:** We may use and disclose your health information to obtain payment for health care services that we or others provide to you. This includes uses and disclosures to:
  - submit health information and receive payment from your health insurer, HMO, or other company that pays the cost of some or all of your health care (payor), or
  - verify that your payor will pay for your health care.

  However, we will comply with your request not to disclose health information to your health plan if the information relates solely to a healthcare item or service for which we have been paid out of pocket in full.

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[1] For purposes of the HIPAA Privacy Rule, USC includes those entities that comprise Keck Medicine of USC, including but not limited to, USC Norris Cancer Hospital, Keck Hospital of USC, USC's employed physicians, nurses and other clinical personnel, those units of USC that provide clinical services within the Keck School of Medicine, School of Pharmacy, the Herman Ostrow School of Dentistry, Physical and Occupational Therapy, Suzanne Dworak-Peck School of Social Work, as well as USC Care Medical Group, affiliated medical foundations of Keck and their physicians, nurses and clinical personnel, Engemann Student Health Center, Eric Cohen Student Health Center, USC Verdugo Hills Hospital, its nurses and other clinical personnel, Verdugo Radiology Medical Group, Verdugo Hills Anesthesia, and Chandnish K. Ahluwalia, M.D., Inc. and those units that support clinical and clinical research functions, including the Offices of the General Counsel, Audit and Compliance.

- **Health Care Operations:** We may use and disclose your health information for our health care operations, such as internal administration and planning that improve the quality and cost effectiveness of the care we provide you. This also include uses and disclosures to:
  - evaluate the quality and competence of our health care providers, nurses and other health care workers,
  - to other health care providers to help them conduct their own quality reviews, compliance activities or other health care operations,
  - train students, residents and fellows, or
  - identify health-related services and products that may be beneficial to your health and then contact you about the services and products.

We may also disclose your health information to third parties to assist us in these activities (but only if they agree in writing to maintain the confidentiality of your health information).

In addition, USC may use and disclose your health information under the following circumstances:

- **Organized Health Care Arrangement.** USC participates in organized health care arrangements (OHCA) with other providers, including but not limited to, Childrens Hospital Los Angeles and Los Angeles County+USC Medical Center (LAC+USC). USC may share information with its OHCA members for treatment, payment and joint health care operations.

- **Directory:** USC may include your name, location in its hospitals, general health condition and religious affiliation in a patient directory without obtaining your authorization unless you object to inclusion in the directory. Information in the directory may be disclosed to anyone who asks for you by name or members of the clergy; provided, however, that your religious affiliation will only be disclosed to members of the clergy.

- **Relatives, Caregivers and Personal Representatives:** Under appropriate circumstances, including emergencies, we may disclose your health information to family members, caregivers or personal representatives who are with you or appear on your behalf (for example, to pick up a prescription). We may also need to notify such persons of your location in our facility and general condition. If you object to such disclosures, please notify your USC health care provider. If you are not present, or the opportunity to agree or object to a use or disclosure cannot practicably be provided because of your incapacity or an emergency circumstance, we may exercise professional judgment to determine whether a disclosure is in your best interests. If information is disclosed to a family member, other relative or a close personal friend, we would disclose only information believed to be directly relevant to the person’s involvement with your health care or payment related to your health care.

- **Public Health Activities:** We may disclose your health information for the following public health activities:
  - To report to public health authorities for the purpose of preventing or controlling disease, injury or disability;
  - To report child abuse and neglect to public health authorities or other government authorities authorized by law to receive such reports;
  - To report information to the U.S. Food and Drug Administration (FDA) about products and services under its jurisdiction;
  - To alert a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease; or
  - To report information to your employer as required under laws addressing work-related illnesses and injuries or workplace medical surveillance.

- **Victims of Abuse, Neglect or Domestic Violence:** If we reasonably believe that you are a victim of abuse, neglect or domestic violence, we may disclose your health information as required by law to a social services or other governmental agency authorized by law to receive such reports.

- **Health Oversight Activities:** We may disclose your health information to a health oversight agency that is charged with responsibility for ensuring compliance with the rules of government health programs such as Medicare or Medicaid.

- **Specialized Government Functions:** We may use and disclose your health information to units of the government with special functions, such as the U.S. military, under certain circumstances required by law.

- **Law Enforcement Officials, Judicial and Administrative Proceedings**: We may disclose health information to police or other law enforcement officials. We also may disclose health information in judicial or administrative proceedings, such as in response to a subpoena.

- **Coroners or Medical Examiners:** We may disclose health information to a coroner or a medical examiner as required by law.

- **Organ and Tissue Donation:** We may disclose health information to organizations that assist with organ, eye or tissue donation, banking or transplant.

- **Health or Safety:** We may disclose health information to prevent a serious threat to your health and safety or the health and safety of the public or another person.

- **Health Information Exchange:** We, along with other health care providers in the Los Angeles area, may participate in one or more Health Information Exchanges (HIE). An HIE is a community-wide information system used by participating health care providers to share health information about you for treatment purposes. Health care providers that participate in the HIE can share your health information electronically. The purpose of the HIE is to allow all health care providers at different facilities participating in your treatment to have all the information necessary to treat you effectively, such as laboratory results, prior diagnosis and current medication. If you do not want to have your health information shared in the HIE you may opt out by completing the Keck Medicine of USC HIE Patient Opt-Out Form.

- **Research:** We may disclose health information without your authorization for certain research purposes. For example, we may disclose your information to researchers preparing a research protocol or if our Institutional Review Board committee (which is charged with ensuring the protection of human subjects in research) determines that an authorization is not necessary if certain criteria are met. We also may provide health information about you (not including your name, address, or other direct identifiers) for research, public health or health care operations, but only if the recipient of such information signs an agreement to protect the information and not use it to identify you.

- **Development Activities:** We may contact you to request a contribution to support important USC activities. For fundraising, we may disclose to our fundraising staff demographic information about you (for example, your name, address and phone number), dates on which we provided health care to you, information about the department of service or treating physician, outcome information or health insurance status without your written permission. We

also may share such information about you with closely related foundations that assist us in our development activities. We will provide you an opportunity to opt-out of receiving fundraising communications. We will not disclose your diagnosis or treatment, however, unless we have your written authorization to do so.

- **Marketing Activities:** We may conduct the following activities without obtaining your authorization:
  - Provide you with marketing materials in a face-to-face encounter;
  - Give you a promotional gift of nominal value;
  - Provide refill reminders or otherwise communicate about a drug or biologic that is currently prescribed to you, so long as any payments we receive for making the communication are reasonably related to our costs;
  - Tell you about USC's own health care products and services

If we accept payments from other organizations or individuals in exchange for telling you about their health care products or services, we will ask for your authorization, except as described above or unless the communications are permitted by law without your permission. We will ask your permission to use your health information for any other marketing activities. Also, from time to time, USC receives letters from patients, their family members and friends describing the experience and care they received at USC. Where possible, we share these letters with our USC employees and patients. Prior to sharing your letter, we will remove your name and other identifying information from the letter to protect your privacy.

- **Workers' Compensation:** We may disclose health information as authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs or as required under laws relating to workplace injury and illness.

- **As Required by Law:** We may disclose health information when required to do so by any other law not already referred to in the preceding categories.

Your Written Authorization

FOR ANY PURPOSE OTHER THAN THE ONES DESCRIBED ABOVE WE MAY ONLY USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION WHEN YOU GIVE US YOUR WRITTEN AUTHORIZATION.

Highly Confidential Information

Federal and state law require special privacy protections for certain highly confidential information about you ("Highly Confidential Information"), including your health information that is maintained in psychotherapy notes or is about: (1) mental health and developmental disabilities services; (2) alcohol and drug abuse prevention, treatment and referral; (3) HIV/AIDS testing, diagnosis or treatment; (4) communicable disease(s); (5) genetic testing; (6) child abuse and neglect; (7) domestic or elder abuse; or (8) sexual assault. In order for your Highly Confidential Information to be disclosed for a purpose other than those permitted by law, your written authorization is required.

Sale of Health Information

We will not make any disclosure that is considered a sale of your protected health information without your written authorization unless the disclosure is for a purpose permitted by law.

Your Rights Regarding Your Health Information

Right to Request Access to Your Health Information: You have the right to inspect and maintain a copy of the patient records we maintain to make decisions about your treatment and care, including billing records. All requests for access must be made in writing. Under limited circumstances, we may deny you access to your records. If you would like access to your records, please ask your healthcare provider for the appropriate form to complete. If you request copies, we will charge you a reasonable fee for copies. We also will charge you for our postage costs, if you request that we mail the copies to you. If you are a parent or legal guardian of minor, certain portions of the minor's medical record may not be accessible to you under California law.

Right to Request Amendments to Your Health Information: You have the right to request that we amend your health information maintained in your medical record file or billing records. If you wish to amend your records, please obtain an amendment request form from your healthcare provider. All requests for amendments must be in writing. We will comply with your request unless we believe that the information that would be amended is already accurate and complete or other special circumstances apply.

Right to Revoke Your Authorization: You may revoke (take back) any written authorization obtained by us for use and disclosure of your protected health information, except to the extent that we have taken action in reliance upon it. Your revocation must be in writing and sent to the USC Office of Compliance or to whoever is indicated on your authorization.

Right to An Accounting of Disclosures of Your Health Information: Upon written request, you may obtain a list (accounting) of certain disclosures of health information made by us. The period of your request cannot exceed six years. If you request an accounting more than once during a twelve (12) month period, we will charge you a reasonable fee.

Right to Request how Information is Provided to You: You may request, and we will try to accommodate, any reasonable written request for you to receive health information by alternative means of communication or at a different address or location.

Right to Request Restrictions on the use of your Health Information: You may request that we restrict the use or disclosure of your protected health information. All requests for such restrictions must be made in writing. While we will consider a request for additional restrictions carefully, we are not required to agree to a requested restriction, except for requests to restrict disclosure of information to a health plan in cases where you have paid for the service out of pocket and in full.

Right to be Notified of Breach: You have the right to be notified by us if we discover a breach of your unsecured protected health information.

Right to a Paper Copy of this Notice: Upon request, you may obtain a paper copy of this Notice, even if you have agreed to receive such information electronically.

Right to Change Terms of this Notice

We may change the terms of this notice at any time. If we change this notice, we may make the new notice terms effective for all health information that we hold, including any information created or received prior to issuing the new notice. If we change this notice, we will post the revised notice in our practice areas and on our website at www.usc.edu/policies. You may also obtain any revised notice by contacting the USC Office of Compliance.

Further Information; Complaints

If you would like additional information about your privacy rights, are concerned that we have violated your privacy rights or disagree with a decision that we made about access to health information, you

may contact our USC Office of Compliance. You may also file written complaints with the Director, Office for Civil Rights of the U.S. Department of Health and Human Services. Upon request, the USC Office of Compliance will provide you with the current address for the Director. We will not retaliate against you if you file a complaint with us or the Director.

USC Office of Compliance

You may contact the USC Office of Compliance at: 3500 Figueroa, #105, Los Angeles, CA 90089-8007, (213) 740-8258 or complian@usc.edu.

UNIVERSITY OF SOUTHERN CALIFORNIA
NOTICE OF PRIVACY PRACTICES

This notice is effective as of April 1, 2018.

Please sign and date below to indicate that you have received a copy of this notice. Your signature simply acknowledges that you received a copy of this notice.

____

Print Name (Last, First, Middle Initial)

____

Signature

____

Date

USC PATIENT EMAIL CONSENT FORM

To address the risks of using email

Patient name: ___________________________
Patient address: _________________________
Email: ___________________
Provider: ______________________________

1. RISK OF USING EMAIL

Transmitting patient information by email has a number of risks that patients should consider before using email. These include, but are not limited to, the following risks:

a) Email can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.
b) Email senders can easily misaddress an email.
c) Backup copies of email may exist even after the sender or the recipient has deleted his or her copy.
d) Employers and on-line services have a right to inspect email transmitted through their systems.
e) Email can be intercepted, altered, forwarded, or used without authorization or detection.
f) Email can be used to introduce viruses into computer systems.
g) Email can be used as evidence in court.
h) Emails may not be secure, including at USC, and therefore it is possible that the confidentiality of such communications may be breached by a third party.

2. CONDITIONS FOR THE USE OF EMAIL

Providers cannot guarantee but will use reasonable means to maintain security and confidentiality of email information sent and received. Providers are not liable for improper disclosure of confidential information that is not caused by Provider's intentional misconduct. Patients must acknowledge and consent to the following conditions:

a) Email is not appropriate for urgent or emergency situations. Provider cannot guarantee that any particular Email will be read and responded to within any particular period of time.
b) Email must be concise. The patient should schedule an appointment if the issue is too complex or sensitive to discuss via email.
c) All email will usually be printed and filed in the patient's medical record.
d) Office staff may receive and read your messages.
e) Provider will not forward patient identifiable emails outside of USC healthcare providers without the patient's prior written consent, except as authorized or required by law.
f) The patient should not use email for communication regarding sensitive medical information.
g) Provider is not liable for breaches of confidentiality caused by the patient or any third party.
h) It is the patient's responsibility to follow up and/or schedule an appointment if warranted.

3. INSTRUCTIONS

To communicate by email, the patient shall:

a) Avoid use of his/her employer's computer.
b) Put the patient's name in the body of the email.
c) Key in the topic (e.g., medical question, billing question) in the subject line.
d) Inform Provider of changes in his/her email address.
e) Acknowledge any email received from the Provider.
f) Take precautions to preserve the confidentiality of email.

4. PATIENT ACKNOWLEDGMENT AND AGREEMENT

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of email between the Providers and me, and consent to the conditions and instructions outlined, as well as any other instructions that the Provider may impose to communicate with patient by email. If I have any questions I may inquire with my treating physician or the USC Privacy Officer.

Patient signature_________________________
Date________________________
Witness signature________________________
Date________________________