OPTUM®

Patient registration 1

☐ **New patient** ☐ **Established patient/updates**

Patient information (Please Print)

Last name: _____ First: _____ Middle: _____

Other name(s) you are also known as: _____

DOB: _____/_____/_____ Sex: ☐ Male ☐ Female

Marital status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

☐ Minor ☐ Other _____ Driver's license number.: _____

Religious affiliation: _____

Required information

Home address: _____ Apt: _____

City: _____ State: _____ ZIP: _____

Phone numbers (please check box of your preferred contact number)

☐ Home: _____ ☐ Cell: _____

☐ Work: _____ Ext: _____

Email: _____

☐ In addition to gaining access to the online health portal, I would like to receive occasional emails with information to help me better manage my health.

Emergency contact

Last name: _____ First: _____ Relationship: _____

Home address: _____ Apt: _____

City: _____ State: _____ ZIP: _____

Home: _____ Cell: _____ Work: _____ Ext: _____

Required Information

Ethnicity (Select one): ☐ Hispanic or Latino or Spanish origin ☐ Decline to state

☐ Not Hispanic, Latino or Spanish origin

Race (Select one): ☐ American Indian-Alaska native ☐ Asian

☐ Black or African American ☐ White or Caucasian

☐ Native Hawaiian or Pacific Islander ☐ Decline to state

Primary language: _____

Employer information

Employer: _____ Date employed: _____

Street address: _____ Suite: _____

City: _____ State: _____ ZIP: _____

Occupation: _____

Have you ever been a patient in any Optum facility before? ☐ Yes ☐ No

If yes, state the location/provider: _____

Responsible party information (do not complete if patient is responsible party)

☐ Single ☐ Married ☐ Separated ☐ Divorced Relationship to patient: _____

Last name: _____ First: _____ Middle: _____

Driver's license number: _____ DOB: ____/____/____

Home address: _____ Apt: _____

City: _____ State: _____ ZIP: _____

Email: _____

Home: _____ Cell: _____ Work: _____ Ext: _____

Health plan information

Primary insurance

Health plan: _____ Eff. date: _____

ID no: _____ Plan: _____ Group no: _____

Subscriber: _____ Phone: _____

Insurance address: _____

Secondary insurance

MediCal identification number: _____

Spouse/other parent's health plan: _____ Eff. date: _____

ID no: _____ Plan: _____ Group no: _____

Subscriber: _____ Phone: _____

Insurance address: _____

_____ _____

Form completed by (print) Date

X _____ _____

Signature Relationship to patient

OPTUM®

OPTUM®

Name: _____

Medical record number: _____

Date of birth: _____

Patient label

Patient registration II

Authorization to treat

I (and/or the undersigned on behalf of the patient) voluntarily consent to allow Optum physicians and staff to provide such evaluation and/or care and treatments as an outpatient on a continuing basis and as an inpatient as necessary, as Optum physicians and staff may decide is advisable and necessary.

I understand that although care is reviewed and supervised by Optum physicians, actual care may be rendered by physician extenders (i.e. physician assistants, nurse practitioners, certified nurse midwife). I further understand that residents, medical students, physician assistant students, nurse practitioner students, nursing students, pharmacy students or other allied health professional students may assist in my treatment.

I am advised that such treatment may include physical examination, X-ray examination, laboratory procedures, other office procedures as well as inpatient procedures as required.

I understand that should I execute a Durable Power of Attorney for Health Care or other Advance Directive, I will provide an executed copy to my physician. I further understand that I will notify my physician of any changes in the Directive.

I understand that I will be informed about the course of my treatment. Also, I am free to terminate my treatment with my Optum physician at any time.

Financial responsibility

I understand that I am financially responsible for all charges, whether or not paid by my insurance, unless specifically exempted by my insurance company's contract with Optum.

Assignment of benefits

I hereby assign medical and/or surgical benefits, private insurance, and any other health plan benefits to Optum. A copy of this assignment is considered valid as the original.

Authorization to release information

I hereby authorize Optum to release any medical information necessary to my insurance company or its agents in order to secure payments.*

Acknowledgment of receipt of notice

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices.

I certify that I have read the foregoing and have received a copy of it. As the patient, the patient's guardian, conservator or general agent, I agree to accept the above terms.

_____ _____

Patient's signature Date

_____ _____ _____

Interpreter (if applicable) Patient's guardian/conservator or general agent Date

See note of _____

Date

_____ _____

Relationship to patient/minor Date

_____ _____

Witness Date

***Special release needed for HIV test results, psychiatric & chemical/alcohol treatment record.**

OPTUM®

Eligibility waiver form

I, _____, hereby certify that I
Name of patient

am eligible for _____ benefits
Insurance name

effective _____. I have chosen **Optum** to be my medical provider. I understand that
Effective date

if the above is not true, I am responsible for all charges related to services provided to me. Also, if

the above is not true, I agree to pay in full for all services received within 30 days of receiving a bill

from **Optum.**

_____ _____
Signature of patient or responsible party Date

_____ _____
Subscriber Social Security number Subscriber name (print)

White copy – Eligibility Yellow copy – Medical records Pink copy – Patient

OPTUM®

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.

Your health information is personal, and we are committed to protecting it.

For purposes of this Notice, Optum and the pronouns "we," "us" and "our" refer to all of the facilities operated by, managed by or affiliated with Optum or any of its affiliates or subsidiaries.

We use and disclose health information about you for treatment, to obtain payment for treatment, for administrative purposes, to evaluate the quality of care that you receive, and for other purposes permitted by HIPAA. We are required by law to maintain the privacy of your health information, to provide you a notice of our legal duties and privacy practices with respect to that information, and to provide you with notice of a breach of your unsecured protected health information.

This Notice applies to all records about your care that are created, and/or maintained by us. Your health information is contained in a medical record that is the physical property of Optum. We are required to abide by the terms of this Notice.

We reserve the right to change our privacy practices, as reflected in this Notice, to revise this Notice, and to make the new provisions effective for all protected health information we maintain. Revised Notices will be available in the clinic, on our website, or upon your request.

How Optum may use or disclose your health information:

We may use or disclose your health information, in certain situations, without your consent or authorization. Below we describe examples of how we may use or disclose your health information as permitted under or required by federal law, including instances where we will obtain your consent or authorization. Such uses or disclosures may be in oral, paper or electronic format.

For treatment. We may use and disclose your health information to provide you with medical treatment or services or to assist in the coordination, continuation, or management of your health care and any related services. This includes the coordination or management of your health care with a third party. For example, a health care provider, such as a physician, nurse, or other person providing health services to you, will record information in your record that is related to your treatment.

This may include interdisciplinary conferences with team members from Optum and support care teams from other facilities involved in your care and treatment or other providers who may be able to provide information or insight in developing and coordinating your plan of care. This information is necessary for other health care providers to determine what treatment you should receive.

For payment. We may use and disclose your health information to others for purposes of obtaining payment for treatment and services that you receive. For example, a bill may be sent to you or to a third-party payer, such as an insurance company or health plan, for care, items or services provided to you. The information on the bill may contain information that identifies you, your diagnosis, and treatment.

For health care operations. We may use and disclose health information about you for operational purposes. For example, your health information may be used by us or disclosed to others in order to:

- Communicate with you about our clinic activities and locations; Evaluate the performance of our staff;
- Assess the quality of care and outcomes in your case and similar cases;
- Learn how to improve our facilities and services;
- Determine how to continually improve the quality and effectiveness of the health care we provide; and
- Train Residents, Medical Students, Nurses, Advanced Practitioners of Nursing, Physician Assistants, Medical Assistants and other health care professional students or interns.

Communications. We may use and disclose your information to provide appointment reminders, leave a brief message on your answering machine, or leave a message with an individual who answers the phone at your residence. We may, from time to time, contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you. In order to better serve you, we may communicate with you about refill reminders and alternative products. We may also provide you with informational materials including information about Optum and its subsidiaries. We may also, at times, send you informational materials about a particular product or service that may be helpful for your treatment. We may also, at times, send you information about how you can participate in the political process to affect your access to health care. Material may also come from a third party.

Required or permitted by law. We may use and disclose information about you as required or permitted by law. If a use or disclosure is required by law, the use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. If required by law, you will be notified of any such uses or disclosures made pursuant to a law.

For example, we may use and/or disclose information for the following purposes:

- For judicial and administrative proceedings pursuant to legal authority;
- To report information related to victims of abuse, neglect or domestic violence;
- To assist law enforcement officials in their law enforcement duties;
- In the instance of a breach involving your unsecured health information, to notify you, law enforcement and regulatory authorities, as necessary, of the situation, and others as appropriate to help resolve the situation; and
- To health oversight agencies responsible for monitoring the health care system and government programs.

Public health. Your health information may be used or disclosed for public health activities such as: (1) assisting public health authorities or other legal authorities to prevent or control disease, injury, or disability; (2) reporting child abuse or neglect to a public health authority or other governmental authority that is authorized by law to receive such reports; (3) reporting information to a person subject to the jurisdiction of the Food and Drug Administration (FDA), for public health purposes related to the quality, safety or effectiveness of FDA-regulated products or activities such as collecting or reporting adverse events, dangerous products, and defects or problems with FDA-regulated products; (4) notifying a person who may be at risk of contracting or spreading a disease, if such disclosure is authorized by law; (5) reporting information to your employer, for the purposes of conducting an evaluation of medical surveillance of the workplace or for the purposes of evaluating whether your have a work- related illness or injury; or (6) disclosing proof of immunization to your school, or your child's school, if the school is required by law to have such proof prior to admitting you or your child. We will obtain and document your agreement to such immunization disclosures.

Individuals involved in your care. We may provide information about you to a family member, friend, or other person involved in your health care or in payment for your health care. If you are deceased, we may disclose medical information about you to a friend or family member who was involved in your medical care prior to your death, limited to information relevant to that person's involvement, unless doing so would be inconsistent with wishes you expressed to us during your life. We will ask you to complete a form to help clarify for us which of your family members and/or friends are likely to be involved with your health care and/or payment for your health care. If we disclose information to a family member, relative or close personal friend, we will disclose only information that we believe is relevant to that person's involvement with your health care or payment related to your health care.

Clinical trials and other research activities. We may use and disclose your health information for research purposes without an authorization from you when an institutional review board or privacy board has waived the authorization requirement. Under certain circumstances, your information may also be disclosed without your authorization to researchers preparing to conduct a research project or for research on decedents or to researchers pursuant to a written data use agreement.

Health and safety. We may, consistent with applicable law and standards of ethical conduct, use or disclose health information about you if we believe that the use or disclosure is necessary to prevent or lessen a serious threat to the health or safety of a person or the public; provided that, if a disclosure is made, it must be to a person(s) reasonably able to prevent or lessen the threat. We may also use or disclose your health information if we believe that the use or disclosure is necessary for law enforcement authorities to identify or apprehend an individual who: (i) admits to participation in a violent crime that we reasonably believe caused serious physical harm to the victim, or (ii) appears to have escaped from a correctional institution or lawful custody.

Notification and disaster relief. We may use or disclose your health information to notify or assist in notifying your family, a personal representative, or another person responsible for your care, of your location, condition, or death. We may disclose your health information to disaster relief authorities so that your family can be notified of your location and condition.

Correctional institutions. If you are an inmate or in the custody of law enforcement, we may disclose your health information to correctional institutions or law enforcement for such purposes as providing care, for the health and safety of yourself or others, for law enforcement at the correctional facility, or for maintenance of safety, security and order at the facility in accordance with state and/or federal regulations.

Decedents. Health information may be disclosed to funeral directors, medical examiners or coroners to enable them to carry out their lawful duties. Once you have been deceased for 50 years (or such other period as may be specified by law), we may use and disclose your health information without regard to the restrictions set forth in this Notice.

Organ/tissue donation. Your health information may be used or disclosed for cadaveric organ, eye or tissue donation and transplantation purposes.

Government functions. We may disclose your health information for specialized government functions, such as military and veterans' activities, national security and intelligence activities, and protection of public officials.

Workers' compensation. Your health information may be used or disclosed in order to comply with laws and regulations related to Workers' Compensation.

Business associates. We may contract with one or more third parties (our business associates) in the course of our business operations. We may disclose your health information to our business associates so that they can perform the job we have asked them to do. We require that our business associates sign a business associate agreement and agree to safeguard the privacy and security of your health information.

Authorizations for other uses and disclosures

While we may use or disclose your health information without your written authorization as explained above, there are other instances where we will obtain your written authorization. Except as otherwise provided in this Notice, we will not use or disclose your health information without your prior written authorization. You may revoke an authorization at any time, except to the extent we have already relied on the authorization and taken action.

Examples of uses and disclosures that require your authorization are:

Psychotherapy notes. If Psychotherapy Notes are created for your treatment, we must obtain your prior written authorization before using or disclosing them, except (1) if the creator of those notes needs to use or disclose them for treatment, (2) for use or disclosure in our own supervised training programs in mental health, or (3) for use or disclosure in connection with our defense of a proceeding brought by you. "Psychotherapy Notes" means notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record. "Psychotherapy Notes" excludes medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.

Clinical trials and other research activities. While we may use or disclose your health information for certain research activities without your authorization (explained above), there are other activities which may require your authorization. When your specific treatment is part of a research study and the exceptions to authorization explained above do not apply, we may disclose your health information to researchers only after you have signed a written informed consent to participate in the research study and a written authorization to use and disclose your health information for research purposes. You do not have to sign the authorization in order to receive traditional services from us. However, if you do not provide written authorization for us to disclose your health information to the researchers, you may become ineligible for the research study itself.

Marketing. If we use or disclose your health information for marketing purposes, we must first obtain your written authorization to do so, except if the communication is face-to-face by us to you, or is a promotional gift of nominal value.

No sale of your health information. We will not sell your health information to a third party without your prior written authorization.

Patient recognition. We strive to celebrate and honor the lives of our patients through a variety of patient recognition activities, such as celebrating birthdays, anniversaries, graduation, weddings and other personal achievements, recognizing health achievements, publishing newsletters, holding patient contests, posting patient photos and fun facts on the facility bulletin board or "Wall of Fame," acknowledging when a patient is hospitalized, and memorializing patients who pass away ("Patient Recognition Activities"). We may also use your information to send you or your family greeting cards as part of our Patient Recognition Activities. Patient Recognition Activities are voluntary. You may participate in these Patient Recognition Activities by executing a written authorization.

Uses and disclosures of your highly confidential information. Some federal and/or state laws require special privacy protections for certain highly confidential health information relating to: (1) psychotherapy services; (2) mental health and developmental disabilities services; (3) alcohol and drug abuse prevention, treatment and referral; (4) HIV/AIDS testing, diagnosis or treatment; (5) venereal disease(s); (6) genetic testing; (7) child abuse and neglect; (8) domestic abuse of an adult with a disability; and/or (9) sexual assault. A summary of applicable laws related to such highly confidential information enacted by states in which our patients reside is attached hereto. Unless a use or disclosure is permitted or required by law, we will obtain your written consent or authorization prior to using or disclosing your highly confidential health information to third parties.

Media. From time to time, media events are hosted at our facilities. The purpose of these events is to raise awareness about chronic health conditions. At these events, there may be individuals from the media as well as our public relations and marketing teams. If your image, voice, or statement is captured on film, we will obtain your written authorization prior to running any news article, press statement, or other publication with your image, voice, or statement. Your participation in these media events and authorization to disclose your likeness is completely voluntary.

Your health information rights

You have the following rights regarding your health information. To exercise any of the rights below, please contact your facility's management to obtain the proper forms.

You have the right to:

- Request that we not use or share certain health information for treatment, payment, or our operations, or request a limit on the health information we disclose about you to someone involved in your care or the payment for your care, like a family member or a friend:
  - If you have paid for a service or health care item out-of-pocket in full, and you ask us not to share that information with your health insurer for purposes of payment or our operations (not treatment), we will agree with your request unless a law requires us to share information.
  - Otherwise, we are not required to agree with your request.
  - Your request must be in writing, and we will notify you of our decision in writing.

- If we do agree to your request, we will comply with your request unless the information is needed to provide you emergency treatment.
- Except for restrictions that we must comply with relating to health plans, we may terminate our agreement to a restriction at any time by notifying you in writing, but our termination will only apply to information created or received after we sent you the notice of termination, unless you agree to make the termination retroactive.

- Obtain a paper copy of this Notice upon request. You may obtain a paper copy of this Notice by visiting your local medical facility. The Notice is also available in your facility and on our website.

- Inspect and obtain a copy of your health and billing records. All requests to inspect or copy your health information must be in writing. An Optum representative can provide a form for you to use. In certain circumstances, we may deny your request, but if we do, we will notify you in writing of the reason(s) for the denial and explain your right to have the denial reviewed. If the information is maintained electronically and if you request an electronic copy, we will provide you with an electronic copy in the form and format requested by you, if it is readily producible in that form and format (if it is not, then we will agree with you on a readable electronic form and format). You can direct us to transmit the copy directly to another person if you submit a signed written request that identifies the person to whom you want the copy sent and where to send it. If you request copies, we may charge a reasonable cost-based fee for the labor involved in copying the information, the supplies for creating the paper copy or the cost of the portable media, postage, and providing a summary of your records, if you request a summary.

- Request an amendment to your health information. You may request that your health record be amended if you believe that the health information we have about you is incomplete or incorrect. Requests to amend your health information must be in writing. An Optum representative can provide a form for you to use. We may deny your request and if we do, we will notify you in writing of the reason for the denial and your right to submit a statement disagreeing with the denial.

- Request confidential communications. You have the right to ask us to communicate health information to you using alternative means or at alternative locations. Such requests must be in writing. An Optum representative can provide a form for you to use. We will accommodate reasonable requests and will notify you if we are unable to agree to your request. We may condition our agreement on information as to how payment will be handled and specification of an alternate address or other method of contact.

- Receive an accounting of disclosures of your health information. You have the right to obtain a list of instances in which we have disclosed your health information, except in certain instances. These instances include: disclosures for treatment, payment and health care operations; disclosures made to you; disclosures incident to a use or disclosure permitted or required by the Federal HIPAA Privacy Rule; disclosures authorized by you; disclosures to persons involved in your care or to disaster relief authorities; disclosures for national security and intelligence purposes; disclosures to correctional institutions or law enforcement officials; disclosures that are part of a limited data set; and disclosures occurring more than six years prior to the date of your request. Your request must be in writing. An Optum representative can provide a form for you to use. The first disclosure list in a year is free; if you request additional lists in any year we may charge you a fee.

Complaints

You may complain to Optum and to the Department of Health and Human Services if you believe your privacy rights have been violated. You will not be retaliated against for filing a complaint.

Contact information

If you have any questions about this notice or our privacy practices, or if you would like to request this notice in another language, please contact your local medical clinic. For complaints, please contact us by phone at **1-844-200-0150** TTY **711** or by email at **privacy@optum.com**

State amendments

The first part of this Notice, which sets forth our privacy practices related to your health information, indicates how we may use and disclose such information under federal privacy laws and regulations. As described in the Notice, there are certain types of highly confidential information that are specifically addressed in certain state laws and regulations, and which further restrict our use and disclosure of this type of highly confidential information. We have set forth below a chart that lists the states in which we reside, **a general description** of the limitations on use and disclosure of certain highly confidential information without your consent, and whether the laws of the particular states address the protection of certain types of highly confidential information. All consents for use or disclosure must meet the requirements of the applicable law.

State law summary table

	California	Florida	Nevada	New Mexico
General health information: State law sets forth restrictions on the use and disclosure of general health information and/or disclosure to only certain persons.	Yes	Yes	No	No
Alcohol and drug abuse records: State law sets forth restrictions on the use and disclosure of alcohol and drug abuse information under certain conditions and/or disclosure to only certain persons.	No	Yes	Yes	Yes
HIV/AIDS: State law sets forth restrictions on the use and disclosure of information related to HIV/AIDS under certain conditions and/or disclosure to only certain persons.	Yes	Yes	Yes	Yes
Mental health records: State law sets forth restrictions on the use and disclosure of mental health records under certain conditions and/or disclosure to only certain persons.	Yes	Yes	Yes	Yes

Communicable diseases: State law sets forth restrictions on the use and disclosure of information related to communicable diseases under certain conditions and/or disclosure to only certain persons.	Yes	Yes	Yes	Yes
Genetic information: State law sets forth restrictions on the use and disclosure of genetic information under certain conditions and/or disclosure to only certain persons.	No	Yes	Yes	Yes
Genetic information: State law regulates the storage or retention of genetic information.	No	No	Yes	Yes
Electronic transmission of health information: State law allows an individual to restrict disclosures of health information in electronic form in certain circumstances.	No	No	Yes	Yes
Prescription information: State law sets forth restrictions on the use and disclosure of prescription information under certain conditions and/or disclosure to only certain persons.	Yes	Yes	Yes	Yes
Immunization information: State law sets forth restrictions on the disclosure of immunization information under certain conditions and/or disclosure to only certain persons.	No	Yes	Yes	No

OPTUM®

HIPAA summary of notice of privacy practices and acknowledgment form

By signing below, I acknowledge that Optum and/or a facility operated by, managed by or affiliated with Optum or any of its affiliates or subsidiaries has/have provided me with a complete copy of its/their Notice of Privacy Practices. This is a summary of the information in the complete Notice of Privacy Practices.

My rights. I have the right to:

- Get a copy of my paper or electronic medical record
- Request corrections to my paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of the complete Notice of Privacy Practices
- File a complaint if I believe my privacy rights have been violated

My Choices. I have some choices in the way the facility uses and shares my information as it:

- Tells family and friends about my condition
- Assists in disaster relief efforts
- Markets its services and sells my information

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for our services
- Help with public health and safety issues
- Do research
- Comply with applicable laws
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other governmental requests
- Respond to lawsuits and legal actions

I have had the opportunity to review the complete Notice of Privacy Practices prior to signing this acknowledgment.

I am aware that the facility reserves the right to change the terms of their Notice of Privacy Practices and to make new provisions effective for all protected health information that they maintain. In the event of amendment(s), the facility will make available a revised Notice of Privacy Practices on its website and at its treatment locations.

_____ _____

Patient or Personal Representative Date

_____

If Personal Representative signs, please state relationship to patient and explain authority to sign

This section is to be completed by the Facility Representative, if unable to obtain written acknowledgment from patient.

I made a good faith effort to explain the purpose and content of the Optum Notice of Privacy Practices to the patient or his/her representative and to obtain an acknowledgment from the patient or his/her representative that the Notice of Privacy Practices was received, but (check one):

_____ Request corrections to my paper or electronic medical record.

_____ Patient was in an emergency treatment situation during first service delivery, and the Notice of Privacy Practices was provided as soon as was practicable after the emergency treatment situation passed.

_____ Other (list reason why acknowledgment was not obtained):

_____

_____

_____

_____

_____

Facility name and address: _____

_____

_____ _____

Employee signature Date

_____

Print name and title of employee

OPTUM®

OPTUM®

Place clinical label here

Permission to discuss personal health information with other individuals

Instructions:

1. Write the name of all family members or other individuals who are involved in the patient's health care, and have the patient or the patient's personal representative sign and date the form.
2. If the patient's personal representative is signing the form on behalf of the patient, the personal representative must also sign and date the acknowledgment that he or she has the legal authority to do so.

Individuals to whom Optum may disclose my personal health information for coordination of care purposes

I hereby grant Optum, its subsidiaries, and associated organizations permission to discuss my health information with the persons listed below as it relates to their involvement in the coordination of my care and payment for health care services I receive.

	Name	DOB	Relationship (friends, relatives, etc.)	Phone #
1.				
2.				
3.				
4.				
5.				

I understand that if I do not list anyone and I am not present or am incapacitated, Optum may share my information with family, friends or others that Optum has determined, based on professional judgment, that is in my best interest and necessary for coordination of care and/or payment for health care services I have received from Optum.

This form supersedes any and all previously completed forms. All previous forms are hereby revoked.

Signature of patient or legal representative _____ Date _____

I understand that I have the ability to revoke identified representatives at any time by making modifications directly to the form and/or choosing to revoke all rights with all identified individuals be selecting option below.

☐ **Revoke all rights to discuss personal health information with all individuals mentioned above**

Signature of patient or legal representative _____ Date _____

Personal representative acknowledgment

If the patient is a minor or has a personal representative, I represent that I am the legal personal representative of the patient named above and I have the legal authority to act on behalf of the patient in making decisions related to health care.

Signature of patient or legal representative _____ Date _____

Print name of patient or legal representative _____

OPTUM®

Advance health care directive acknowledgement

Optum in compliance with the Patient Self Determination Act of 1990, ensures a patient's right to self-determination by inviting patients to participate in decisions about their health care. This is accomplished through the planning and communication of their medical treatment wishes through an Advance Healthcare Directive Acknowledgement Form.

My initials next to one of the following statements indicates my current Advance Directive status:

Initials	Statement
	I have provided a copy of my Advance Healthcare Directive Form to Optum to be placed in my chart. ☐ *Scanned to EHR*
	I will provide a copy of my Advance Healthcare Directive to Optum.
	I do not have an Advance Healthcare Directive at this time. I understand that it is my responsibility to discuss this matter with my primary care provider.

My Signature acknowledges that I have informed Optum of my right to participate in making decisions about my medical treatment by executing an Advance Healthcare Directive.

Signature	Printed Name	Date
Patient:		
Witness:		

For Office Use Only:

☐ Written and Verbal information was provided to the patient. (Advance Healthcare Directive Packet)

Comments:
