# Woodcreek Pediatrics

Mary Bridge Children's

# PATIENT GUIDE

Conditions for Treatment
Financial Policy
Notice of Privacy Practices
Patient Rights and Responsibilities
Understanding Your Bill
Financial Assistance

Rev: 1/2018 v7

# Acknowledgement of Conditions for Treatment & Financial Disclosures

**The undersigned Patient and/or Patient's Representative hereby acknowledges receipt of Woodcreek Pediatrics - Mary Bridge Children's handout titled "Patient Guide" which includes sections relating to: Conditions for Treatment, Notice of Privacy Practices, Patient Rights and Responsibilities, Understanding Your Bill, Financial Policy, and Financial Assistance.**

## CONSENT FOR CARE

I agree to care and treatment by Woodcreek Pediatrics - Mary Bridge Children's ("WPMB") and the physicians, surgeons and other licensed independent practitioners involved in my care, together with other health care professionals employed by or otherwise affiliated with WPMB who are designated to provide care for me. This consent may include examinations, tests, imaging studies, labs, anesthesia, and medical or surgical treatment(s). Additional documents and consent forms may be required for specific procedures. I understand I have the right to ask questions about my care at any time, and to be involved in my care decisions.

## RISKS OF TREATMENT: NO GUARANTEE OF RESULTS OR CURE

No promise or guarantee of results or cure has been made to me. I know there are risks related to surgical, medical, or diagnostic procedure(s). These risks include the potential for infection, blood clots in veins and lungs, bleeding, allergic reactions, and death.

## PHOTOGRAPHS FOR TREATMENT, DIAGNOSIS AND/OR IDENTIFICATION

For diagnosis and treatment purposes, I allow images such as photographs to be taken and used. This includes video and electronic monitoring or recording methods. These images may be used to add to written information about my illness or injury.

Some images are used once and immediately discarded when no longer needed. Others may be kept as part of my medical record, at the option of my treatment providers. Photographs of me may also be taken for identification purposes.

## IMAGES OR RECORDINGS OF HEALTH CARE PROVIDERS

I understand I must obtain the permission of all health care provider(s) and any other individuals present before I can take photographs or video of any members of my care team.

I also understand I cannot record conversations by any means without first obtaining the permission of all persons being recorded.

## NON-EMPLOYED PHYSICIANS & PROVIDERS

I understand there may be physicians or other licensed providers who practice at WPMB who are not employed by WPMB. These individuals are independent providers and are not employees or agents of WPMB. These include anesthesiologists, radiologists, pathologists, neonatologists, and PICU physicians. It also includes Allenmore, Good Samaritan, Covington, Auburn Medical Center and Tacoma General emergency department physicians and providers. I understand these providers use their own independent judgment in their medical care and treatment. WPMB does not control the medical care and treatment given by these providers. I understand that WPMB has provided me with a list of all independent providers or groups who provide care to me, together with their contact information within this handout (Understanding Your Bill section). I understand that I may receive separate bills for services provided by those parties.

## FINANCIAL AGREEMENT

I agree to pay WPMB for care at its regular rates and terms applicable to my care and any applicable health insurance coverage I have.

I permit WPMB to appeal any denial received from my insurance company. If a third-party payor will not pay, I agree to pay for the services given, subject to any applicable contractual or governmental regulations. If a third party caused my injuries, I understand that WPMB may file a medical services lien as permitted under RCW 60.44.010. (This lien attaches only to a portion of the proceeds of any settlement between me and the party that caused me harm.) If my bill is sent to a lawyer or collection agency, I will pay all reasonable attorneys' fees and costs, together with interest and any amounts otherwise found to be owing. Information about the estimated charges for health services is available upon request. I understand I have the right to request this information.

## AGENTS & CONTRACTORS

Whenever WPMB is referenced above, it is my intent to include its employees, officers, agents, attorneys, first and third-party liability and claims agents, third-party claims administrators and collection agencies, as well as their agents or employees, to receive any information that WPMB would otherwise be entitled to receive.

## MEDICARE

If I am a Medicare participant, I understand that I need to pay for services that are not covered by the Medicare Program. This may include, but is not limited to, cosmetic surgery, dental care, take-home and "over the counter" medications, private duty nurses, services not medically needed, personal items, services covered by car or liability insurance, or where a third party is otherwise responsible for any accident or injury leading to my need for care, as well as any services not otherwise covered by Medicare. If I remain in the hospital at any time after it has been determined that Medicare-covered services are no longer medically necessary, I understand that I will be personally responsible for paying for such services after I am decertified as a Medicare-covered patient.

## CO-INSURANCE

There may be a co-insurance for care given related to my Medicare or other insurance benefits. I know I will need to pay a higher co-insurance for services provided by a hospital-based clinic or department. If these services were given in a non-hospital based setting, my co-insurance would be lower.

## PHONE, EMAIL, TEXT MESSAGING AUTHORIZATIONS

I grant permission and consent to Woodcreek Pediatrics - Mary Bridge Children's: (1) to contact me by phone at any phone number associated with me, including wireless (cell) numbers; (2) to leave answering machine and voicemail messages for me, and include in any such messages information required by law (including debt collection laws) and/or regarding amounts owed by me; (3) to send me text messages or emails using any email or cellular device addresses I provide and; (4) to use pre-recorded/artificial voice messages and/or and automatic dialing device (an "autodialer") in connection with any communications made to me or related to my scheduled services and my account, unless I have exercised an "opt out" option associated with such emails or text messages or have otherwise notified WPMB in writing to discontinue such communications using those pathways.

I understand that opt out processes may take up to ten (10) business days to go into effect. I understand that I am not required to accept messages in these formats as a condition of receiving services at WPMB.

## EMAIL CONTAINING PROTECTED HEALTH INFORMATION; "YOURACCESS"

I understand that exchanging email, text or other written communications with my health care provider(s) or other members of my care team can result in protected health information being disclosed to unauthorized persons, and that WPMB cannot control who views such information when sent in unencrypted form.

I understand that WPMB offers "YourAccess" to all patients, which provides a fully encrypted and protected pathway for communicating with most of its providers. If I initiate or respond to communications using unencrypted pathways, I assume the risk that my information may be compromised, and I authorize WPMB and its providers to communicate with me using that process, unless or until I choose to opt out of such communications pathways by notifying WPMB in writing, allowing up to ten (10) business days to implement any change in my communications pathways.

## ADVANCE DIRECTIVES / LIVING WILL / POLST FORMS

I understand that I have the right to carry out an Advance Directive for Health Care (Often referenced as a "Living Will."). I understand I can get information on the Advance Directive policy at www.multicare.org/important-policies. I understand that POLST form (Physician's Orders for Life Sustaining Treatment) may not always serve as a substitute for an Advance Directive. If I have completed a POLST or Advance Directive form, I agree to provide a copy of such form(s) to WPMB. I also understand that I can complete a separate Advance Directive for Mental Health.

## HEALTH CARE POWER OF ATTORNEY / MENTAL HEALTH POWER OF ATTORNEY

I understand I can nominate another person or persons to make health care decisions for me at times when I am unable to do so. These can include routine health care decisions (including life and death decisions) as well as mental health decisions. Examples of these can be found at: www.woodcreekhealthacre.com/forms. If I complete either of these forms, I will provide WPMB with copies, or otherwise tell WPMB where they are located.

## NO SHOW/LATE CANCELLATION POLICY

It is necessary for us to make appointments to see our patients as efficiently as possible. No-Shows and late cancellations cause problems that impact our practice. When an appointment is made and it is not kept, it takes an available time slot away from another patient. No-Shows and Late Cancellations delay the delivery of health care to other patients, some who are quite ill.

A "No-Show" is missing a scheduled appointment.

A "Late Cancellation" is an appointment cancelled less than 24 hours in advance.

We understand that situations such as medical emergencies occasionally arise when an appointment cannot be kept and adequate notice is not possible. These situations will be considered on a case-by-case basis.

A charge of **$35.00** may be assessed for each no-show and a fee of **$25.00** for each late cancellation of an appointment.

**Please understand that insurance companies consider this charge to be entirely the patient's responsibility.**

### *Acknowledgement*

This consent will remain valid for one year from the date of signature.

_____

Signature

_____

Full Name

_____

Relationship to Patient

_____

Date

# Conditions for treatment

## Consent for Care, Financial Disclosures & Patient's Rights Materials

### WOODCREEK PEDIATRICS - MARY BRIDGE CHILDREN'S

I understand that Woodcreek Pediatrics – Mary Bridge Children's ("WPMB") operates numerous inpatient and outpatient clinics, and urgent care. For a complete list of all WPMB locations, see www.woodcreekhealthcare.com. I understand that portions of my care may be rendered at more than one site or location, even when I do not move between facilities.

### RELEASE OF INFORMATION

WPMB may use and disclose my information for the purposes of continuity of care, payment for health care services rendered, and for its own health care operations, and when required to do so by Federal and state law. Federal and state law may place limitations on the use and disclosure of my health information, particularly if it pertains to drug or alcohol treatment, mental health treatment, and diagnosis or treatment of sexually transmitted diseases.

### PAYMENT INFORMATION

To receive payment for care, WPMB may need to disclose protected health information such as my name, address, date of birth, admission/discharge date(s), telephone numbers, social security number, medical records, account numbers, insurance information and charges at WPMB, along with the circumstances leading to my need for treatment. This information may be shared with applicable sources of payment for the health care services provided to me. See WPMB's Notice of Privacy Practices for more detail: https://www.woodcreekhealthcare.com.

### HEALTH CARE WORKER EXPOSURE / BLOOD TESTING

I agree that if any health care worker (including police, fire or other first responder) is exposed to my blood or other body fluids, WPMB may test my blood, tissue or other body fluid for communicable disease, such as hepatitis, HIV or syphilis, or other communicable diseases. I understand that any test result received because of such exposure may not appear in my medical record unless I am separately treated for any positive test results at a WPMB facility. My test results may be shared with the exposed worker and/or their health care provider(s). I understand that a positive HIV or Hepatitis C Antibody test must be reported to the local Health Department. I understand that I may be contacted by WPMB or others if my test is positive.

### SUPPLEMENTAL INFORMATION

I acknowledge that I have been provided and/or offered the following brochures or information, and I understand that additional copies are available upon request in hard copy and/or on the WPMB website: www.woodcreekhealthcare.com. Many of WPMB's forms are also translated into other languages, and I will ask if a translated version of any form is needed:

***Patient Rights & Responsibilities:*** This contains valuable information about my rights and responsibilities as a patient. It includes WPMB's procedures to resolve complaints.

***Notice of Privacy Practices:*** This describes how WPMB may use and share my personal health information, and how its participation in various Organized Health Care Arrangements and/or Clinically Integrated Networks or other Accountable Care Organizations may impact the use of my protected health information.

***Financial Assistance:*** WPMB offers Financial Assistance based on an individual's ability to pay for medically necessary health care services.

To learn more about Financial Assistance options, call 253.848.8797 or visit https://www.multicare.org/financial-assistance/.

***Other:*** I may also be provided with other brochures or documents pertaining to my specific health conditions, now or at a later time. These may include communications that relate to my gender, age and generalized health condition, or that may relate to specific diagnoses, as well as general or specific information about programs or services offered by, or in conjunction with, WPMB.

***Victims of Crime:*** If you were the victim of a crime, resources may be available through Crime Victims Compensation Program (CVCP) to assist with the many costs associated with violent crime. For more information on medical treatment and counseling services, contact the CVCP at 1.800.762.3716 or visit www.CrimeVictims.Lni.wa.gov.

***ESL / Translation Services:*** If English is a second language for you, and/or you otherwise need the assistance of a translator, please let us know and services will be provided.

### DISCRIMINATION

WPMB does not discriminate against any person on the basis of race, color, national origin, disability, religion, faith, age, gender or sexual orientation in care and treatment or participation in its programs, services, activities or employment.

If you are concerned about discrimination at WPMB, please contact us at: Woodcreek Pediatrics - Mary Bridge Children's, Attn: Compliance Officer, 11102 Sunrise Blvd E, Suite 103, Puyallup, WA 98374.

### ASSIGNMENT OF BENEFITS; PERMISSION TO ALLOW WOODCREEK PEDIATRICS – MARY BRIDGE CHILDREN'S TO DETERMINE, APPLY AND OBTAIN BENEFITS, INFORMATION AND PAYMENT

I permit payment from insurance or other third-party payors to go to Woodcreek Pediatrics – Mary Bridge Children's ("WPMB") directly. I permit WPMB, in WPMB's sole judgment, to determine, apply for and obtain benefits, and get paid from, any and/or all available payor sources until my bill is paid in full. I understand and agree that, to the extent necessary to receive payment or reimbursement for services provided at WPMB, I authorize WPMB to, access any applicable accident reports, industrial injury (workers compensation) reports and/or police, fire or other first responder reports or investigations related to my treatment or injury, as well as any records of any claims, lawsuits, insurance claims or investigations that pertain to my medical care and treatment, or the circumstances leading to same, together with any applicable consumer and/or credit reports pertaining to me. I further authorize any applicable Federal, State or Local government or administrative agency to fully and completely release any and all of my records and/or incident information

they have about me, pertaining to my care or the circumstances leading to my need for care, upon request by WPMB.

### STUDENT CARE PROVIDERS

Under supervision of my health care team, I understand that medical residents, medical students, nursing students or other trainees may take part in my care and treatment.

### VALUABLES

If I retain any valuables, such as wedding rings, jewelry, wrist watches, dentures, eyeglasses, hearing aids or other personal effects, instead of sending them home or placing them in safekeeping with WPMB, WPMB shall not be responsible for loss or damage to any personal property kept by me. I acknowledge that WPMB recommends that I do not bring or keep valuables with me during my time at WPMB facilities.

### DISPOSAL OF REMOVED TISSUE

I allow my physician or surgeon, and/or WPMB, to decide whether to retain or dispose of any tissue removed during any examination, treatment or procedure(s).

### PATIENT SATISFACTION SURVEYS

I agree that WPMB may contact me after my care or treatment to ask about my experience as a patient. I understand that WPMB may use an independent agency to do this survey. I know I am not required to respond to the survey, and my participation (or not) in any survey will not impact any care that I receive.

### DISRUPTIVE BEHAVIOR

I understand that WPMB has a "zero tolerance" policy for disruptive behavior, which includes any behavior that makes it difficult for the care team to provide services. This policy protects all patients, families, visitors and WPMB employees and providers. I agree to report any disruptive behavior to my health care team and I will take all steps that I reasonably can to avoid participating in any disruptive behavior myself, or through any friends or family members. Individuals engaged in disruptive behavior may be precluded from calling, visiting or otherwise participating in my care.

### SURROGATE DECISION-MAKERS

If I am unable to sign this acknowledgment myself, I understand that my statutory surrogate decision-maker(s) will sign this acknowledgment for me, unless my consent for treatment is otherwise implied under Washington law (i.e. due to a medical emergency.) If this acknowledgment is signed by a surrogate, it shall have the same force and effect as if signed by me directly, at a time and under circumstances when I would otherwise have been deemed to be competent. I understand the importance of telling my potential surrogate decision-makers of my wishes through the use of health care advance directive forms or others means, as my health conditions change over time.

# Financial Policy

### UNDERSTANDING YOUR BENEFITS

Please familiarize yourself with your insurance benefits and verify that the provider you are seeing is part of the preferred provider network. Your health plan mandates that you are financially responsible for payment of all copays, deductibles, and non-covered services, and Woodcreek Healthcare is contractually obligated to collect them. We do not verify insurance benefits, which is why we highly recommend that you contact your insurance company and familiarize yourself with your policy's benefits. For a list of services and codes for well child exams, visit our website at www.woodcreekhealthcare.com.

### RESPONSIBLE PARTY

You are financially responsible for paying for services that are provided to you by our providers. If the patient is a child, the responsible party will be the biological parent and/or the assigned representative authorized to seek medical care for the child and is the party that brings the child in for services. Woodcreek Healthcare is not obligated to follow civil court decisions, including financial obligations for divorce decrees or parenting plans.

### UNDERSTANDING OUR CHARGES

Patients will be charged for each service that is performed during an office visit. Included in the base charge for an office visit is a discussion about the nature of the illness, an examination of the patient, medical decision making, development of a treatment plan and discussion with the patient about the plan. Other activities (procedures) are billed in addition to the charge for the examination. These charges could include, but may not be limited to, sutures, wart removal, vision and hearing tests, removing wax or foreign bodies from the ears or nose, lab tests, administration of immunizations, and other additional services. It is Woodcreek policy that medical staff members do not quote fees for services or supplies, but you may ask the provider or the nurse to contact the front desk or billing office to learn the exact cost of the procedure, test or lab service before it is provided.

### CO-PAYMENTS

Co-payments are due at the time you are checking in for your appointment.

### NO-SHOW OR LATE CANCELLATION APPOINTMENTS

If you miss a scheduled appointment you may be charged a $35.00 no-show fee or if you cancel your appointment less than 24 hours in advance you may be charged a $25.00 late cancellation fee. If you fail to cancel multiple appointments, the provider may elect to withdraw as your treating physician and you will be asked to find another doctor. Please see our entire No-Show/Late Cancellation Policy at www.woodcreekhealthcare.com.

### ACCOUNT BALANCE

You will be asked to pay your current account balance at each visit. We will make every effort to inform you of your balance when your appointment is scheduled so that you will be prepared to make the payment prior to or at the time of your appointment.

### DEDUCTIBLE/COINSURANCE

We may ask you to make a deposit toward the patient portion of the deductible and coinsurance at each visit.

### BILLING STATEMENTS

Our office is contracted with many insurance carriers. If we are contracted with your insurance company, you will receive a billing statement from us after the insurance has processed your claim. Your charges will be listed along with any payments received from you and

your insurance company. This listing will correspond to the explanation of benefits (EOB) that you will receive from your insurance company. You will receive a statement from our office every twenty-five (25) days until the balance is paid in full. We offer statements by paper or e-statements that come directly to your email. **All balances are due and payable within thirty (30) days of the initial statement date unless prior arrangements have been made.**

## REBILLING FEE

After 30 days, a $7.50 rebilling fee will be added to your account every twenty-five (25) days until your balance is paid. The person requesting treatment is responsible for all services rendered. However, if the patient is a minor, the custodial parent or guardian is responsible for the payment. of your statement. If you are unable to pay the entire amount due, please contact our patient account representatives at 253.848.8797 and following the prompts to the billing department.

## RETURNED CHECK FEE

A returned check fee of $30 will be charged to your account for all returned checks.

## PAYMENT OPTIONS

Woodcreek Healthcare accepts checks, money orders, VISA, MasterCard, Discover, and American Express. Credit card payments can be made in person, by mail, online, or over the phone by calling 253.848.8797 and following the prompts to the billing department.

## COLLECTIONS

If your unpaid account is sent to an outside collection agency, Woodcreek Healthcare may permanently discontinue providing medical care for any current or future family members.

## DEFINITIONS

***Deductible*** -A deductible is the amount you pay for health care services before your health insurance begins to pay. For example, if your deductible is $1,500, you would pay 100 percent of your health care charges until the amount you have paid reaches $1,500. After that, some services you receive may be covered at 100 percent, or you may have to pay coinsurance.

***Co-insurance*** - Co-insurance is your share of the cost of a health care service. Coinsurance is usually figured as a percentage of the total charge for the service. You are responsible for coinsurance plus any deductibles you still owe. For example, you've already paid out (or met) your $1,500 deductible and your coinsurance is 20 percent. For a $100 health care bill, you would pay $20 and your insurance company would pay $80.

***Co-pay*** - A co-pay is a fixed amount you pay for a health care service this is set by insurance companies. It is paid prior to when you receive the service. The amount can vary by the type of provider or service. For example, a doctor's office visit might have a co-pay of $30. The co-pay for an emergency room visit will usually cost more, such as $150.

# 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.**

## WHO WILL FOLLOW THIS NOTICE

This Notice describes the practices of MultiCare Health System ("MultiCare") and that of:

- Any health care professional authorized to enter information into your chart at any MultiCare facility.
- All departments and units of MultiCare.
- Any member of a volunteer group we allow to help you while you are at a MultiCare facility.
- All MultiCare employees and personnel including contracted or agency staff.
- Other health care providers who have agreed to follow and abide by the "joint notice of privacy practices" terms described below.

## JOINT NOTICE OF PRIVACY PRACTICES

In addition to those persons identified above, a number of other independent practitioners have agreed with MultiCare to follow this Notice as a joint privacy practices notice in accordance with federal privacy laws related to care delivered at MultiCare facilities. The independent practitioners that have agreed to follow this Notice may access your health information where there is a legitimate need to do so for treatment, payment and health care operations purposes related to the joint care setting at MultiCare facilities. The independent practitioners that have agreed to follow this joint notice likely will have separate Notice of Privacy Practices for care delivered at non-MultiCare facilities (e.g. a physician's office). You are encouraged to request information from a non-MultiCare practitioner about any separate Notice of Privacy Practices followed by that practitioner at non-MultiCare offices or facilities.

### Community Provider Access to Your Electronic Health Record

To improve care, quality outcomes and access to your health records by providers in the community, MultiCare may provide connectivity to its Electronic Health Record system to independent community health care providers and members of the medical staffs of MultiCare's affiliated hospitals ("Connected Providers"). As a condition of such access, Connected Providers each agree to abide by appropriate privacy and security measures, including compliance with federal and state laws regarding the privacy and security of your health information. Connected Providers with a "need to know" typically have full access to your electronic health record. For any questions concerning MultiCare's role in providing electronic records access to Connected Providers, please call our Privacy Office at 253.459.8300. MultiCare also provides you with limited access to your electronic health record under Woodcreek Pediatrics – Mary Bridge Children's "YourAccess" patient portal. For information on "YourAccess", see www.woodcreekhealthcare.com/youraccess.

## MULTICARE CONNECTED CARE NETWORK

We are part of the MultiCare Connected Care Network which is an organized healthcare arrangement (OHCA). An OHCA is (i) a clinically integrated setting in which individuals typically receive healthcare from more than one healthcare provider or (ii) an organized system of healthcare in which more than one health care provider participates. The healthcare providers who participate in the OHCA will share medical and billing information about you with one another as may be necessary to carry out treatment, payment, and healthcare operations activities.

## MULTICARE'S PLEDGE AND RESPONSIBILITIES REGARDING YOUR PROTECTED HEALTH INFORMATION

We understand that medical information about you and your health is personal. We are committed to protecting health information about you and are required under federal and state law to take steps to protect this information. Under federal privacy laws, this information is called "protected health information." Protected health information includes certain information we have created or received that identifies you, including information regarding your health or payment for your health at a MultiCare facility, whether by MultiCare personnel, your personal doctor or other practitioners involved in your care. It includes your medical records and personal information such as your name, social security number, address, and phone number.

### *MultiCare is required by law to:*

- Take steps to protect the privacy of the medical information that identifies you;
- Provide you this Notice of our legal duties and privacy practices with respect to medical information about you;
- Notify you following a compromise of unsecured protected health information; and
- Follow the terms of the Notice that is currently in effect.

## USES AND DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION BY MULTICARE

MultiCare uses and discloses your protected health information in many ways related to your treatment, payment for your care, and our health care operations. Some examples of how we may use or disclose your protected health information are listed below.

### *Your authorization is required in the following circumstances:*

- The use and disclosure of psychotherapy notes;
- Disclosures that constitute a sale of protected health information;
- The use and disclosure of your protected health information for marketing purposes where we receive financial remuneration; and
- For any other uses and disclosures not described in this Notice of Privacy Practices.

### *We may use or disclose your protected health care information to provide you with medical treatment or services without a signed consent for continuity of care:*

- To doctors, nurses, technicians, health care students, or other health system personnel who are involved in your care.
- To different departments to coordinate activities such as prescriptions, lab work and x-rays.
- To other health care providers who may be involved in your medical care, such as long-term care facilities, other hospitals or clinics, or remote health care providers such as the services offered by telemedicine providers who may reside in other communities, including communities outside of Washington.

Federal and state laws may place additional limitations on the use of your protected health information for drug or alcohol abuse, sexually-transmitted diseases, or mental health treatment.

### *As permitted by law, we may use or disclose your protected health information in relation to payment for health services you receive.*

- To bill for treatment and services you receive at a MultiCare facility.
- To collect payment for treatment and services you receive at a MultiCare facility.
- To obtain prior approval for treatment and services from your insurance plan.

### *We may use or disclose your protected health information in relation to health system operations.*

- To administer or support our business activities or those of other health care organizations (as allowed by law) including providers and insurance plans.
- To other individuals (such as consultants and attorneys) and organizations that help us with our business activities. (Note: If we share your protected health information with other organizations for this purpose, they also must agree to protect your privacy).

These uses and disclosures are necessary to operate the health system and ensure patients receive quality care. Examples could include review of treatment to evaluate staff or identify training needs, to review outcomes of care, or to send you a patient satisfaction survey.

### *We may also use or disclose your protected health information in the following miscellaneous circumstances.*

**Contacting You** – We may use and disclose health information to reach you about appointments and other matters. We may contact you by mail, telephone, or email. For example, we may leave voice messages at the telephone number you provide us with, and we may respond to your email address.

**Treatment Alternatives** – To tell you about or recommend possible treatment options or alternatives.

**Health-Related Benefits and Services** – To tell you about health-related benefits, services, or medical education classes.

**Business Associates** – We may disclose your health information to other entities that provide a service to us or on our behalf that requires the release of your health information, such as billing service, but only if we have received satisfactory assurance that the other entity will protect your health information.

**Organized Health Care Arrangements (OHCA)** – An organized healthcare arrangement is characterized by separate healthcare providers that participate in joint activities to share protected health information about their patients in order to deliver healthcare together and improve

hospital operations. These are common hospital settings, but are expanding to include a wide range of ambulatory outpatient care across all health care service lines.

**Fundraising Activities** – Limited information about you (name, address, phone number, email, age, date of birth, gender, health insurance status, treating physician, dates, and departments of service at WPMB) may be used and disclosed to support MultiCare's fundraising activities. If you no longer wish to receive fundraising requests supporting MultiCare, please call (toll free) 855.884.4284, or alternatively send an e-mail to annualgiving@multicare.org. We respect your choice regarding fundraising communications and your decision will have no impact on your treatment or payment for services at MultiCare.

**Marketing Materials** – Limited information about you may be used to support communication about available products or services. If you do not wish to receive such materials, please call 253.403.1261.

**Health Information Exchanges –** We may participate in health information exchange networks to facilitate the secure exchange of your electronic health information regarding your treatment between and among other health care providers or health care entities including but not limited to Emergency Department Information Exchange (EDIE), Virtual Lifetime Electronic Record (VLER - DoD/VA), or CareEverywhere (Organizations with Epic).

**Research** – For research purposes, under certain circumstances. All research projects, however, are subject to a special approval process. Unless specially approved, we will ask for your specific permission to determine if the researcher will have access to your name, address or other information that reveals who you are or will be involved in your care at the health system.

**Telemedicine** – Modern technologies are enabling new methods of delivering health care in circumstances where the patient is in one location and the health care provider is at another location. Telemedicine providers may be consulted by your physicians or other care team members, and at times you may interact directly with a telemedicine provider using technologies to allow direct communication.

In most circumstances, your telemedicine provider will have direct access to your medical records in the same manner, and often to the same extent, that your local "in person" health care providers have.

**As Required By Law** – When required to do so by federal, state or local law.

### *We may also use or disclose your protected health information in the following special situations:*

**Organ and Tissue Donation** – If you are an organ donor, to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transportation.

**Blood Conservation Services** – If you have indicated affiliations with certain organizations and we believe you may be an ideal candidate who could benefit from blood conservation services.

**Military** – As required by law, if you are a member of the armed forces.

**Workers' Compensation** – As properly requested by workers' compensation or similar programs, including providing a report of accident with the state Labor & Industries Department or another's worker's compensation program.

**Public Health and Safety** – To agencies when necessary, to prevent a serious threat to your health and safety or the health and safety of the public or another person.

These activities generally include the following:

- To prevent or control disease, injury or disability;
- To report births and deaths;
- To report abuse or neglect;
- To report reactions to medications or problems with products;
- To notify people of recalls of products they may be using;
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure when required or authorized by law.

**Health Oversight Activities** – To a health oversight agency for activities authorized by law such as audits, investigations, inspections, and licensure.

**Lawsuits and Disputes** – In response to a court or administrative order, subpoena, discovery request, or other lawful process, if you are involved in a lawsuit or a dispute.

**Law Enforcement** – To law enforcement officials in limited circumstances for law enforcement purposes such as locating a suspect, fugitive, material witness, or missing person; reporting a crime; or providing information about a victim of a crime, if under certain limited circumstances, we are unable to obtain the person's agreement.

**Coroners, Medical Examiners, and Funeral Directors** – To coroners, medical examiners, or funeral directors as required by law and necessary to perform their duties.

**Military Activity and National Security** – To authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law or in connection with providing protection to the United States President, other authorized personnel or foreign heads of state or conducting special investigations.

**Correctional Facilities** – To a correctional facility or law enforcement official, if you are an inmate or under custody.

## USE AND DISCLOSURE WHEN YOU HAVE THE OPPORTUNITY TO OBJECT

**Patient Directory** – We will include limited information about you in the patient directory while you are a patient at a MultiCare hospital or MultiCare facility. This information may include your name, location in the hospital/facility and your general condition (e.g. fair, stable, etc.) and, with your permission, your religious affiliation. The directory information, except your religious affiliation, may be released to people who ask for your by name unless you have instructed us not to do so. Also, with your

permission, we may tell members of the clergy your religious affiliation. This information helps your family and friends visit you in the facility and know your general health condition.

**Individuals Involved in Your Care** – Unless you object, your healthcare provider will use his or her professional judgment to provide relevant protected health information to your family, friends, or another person. This person would be someone you indicate has an active interest in your care or the payment for your healthcare or who may need to notify others about your location, general condition or death.

**Disaster Relief** – We may disclose to an organization assisting in a disaster relief effort so that your family and friends can be notified about your general health condition and location.

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest.

We may also share your information when needed to lessen a serious and imminent threat to health or safety.

## OTHER USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

Other uses and disclosures of your protected health information not covered by our current Notice or applicable laws will only be made with your written permission.

You may revoke any permission by submitting a request in writing to the MultiCare Privacy Office (at the contact information under Questions & Complaints). If you revoke your permission, we will no longer use or disclose your protected health information for the reasons covered by your written authorization unless required by law. You understand that we are unable to take back any uses or disclosures we have already made, while your permission was in effect, and that we are required to retain our records of the care that we provide to you.

## YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

Unless indicated otherwise, you may exercise one of your privacy rights by submitting a written request to: MultiCare Health System, Health Information Management, PO Box 5299, MS: 315-C3-HIM, Tacoma, WA 98415-0299. For more specific instructions on what information to include in a written request, contact Health Information Management by phone 253.403.2433.

## YOU HAVE A RIGHT TO

**Request to inspect and/or copy your protected health information that may be used to make decisions about your care** – Usually this includes medical and billing records and does not include psychotherapy notes. To request an opportunity to inspect and/or copy your protected health information in either paper or electronic format, visit www.multicare.org to obtain a copy of the authorization request form or contact Health Information Management (medical records) at 253.403.2433 for inpatient records and 253.372.7175 for any MultiCare Clinic outpatient records. You may be charged a fee for copying, mailing or other supplies associated with your request. In certain limited circumstances, we may deny your request to inspect and/or copy your protected health information. You may request that the denial be reviewed.

**Ask us to amend certain protected health information** – If you feel that information we have about you is incorrect or incomplete you can request an amendment to such information.

**Request an accounting of certain disclosures** – You may request an accounting of certain disclosures of protected health information we have about you listing all the disclosures we made of your protected health information to others except for the purposes of treatment, payment, and health care operations identified previously. The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

**Request restrictions** – You may request in writing that we limit the way we use and disclose your protected health information. You also have the right to request a limit on the protected health information we disclose about you to someone who is involved in your care or the payment of your care, like a family member or friend. If you want to put such a restriction in place, please notify your healthcare providers.

We are not legally required to agree to all restriction requests. If we do agree to your request, we will comply unless the information is needed to provide emergency treatment.

**Right to request nondisclosure to health plans for self-paid items or services** – You have a right to request in writing that healthcare items or services for which you self-pay for in full in advance of your visit not be disclosed to your health plan (except as otherwise required by law). You are responsible for notifying any other providers, such as your pharmacy, of any restriction requests.

**Request confidential communications** – You may request in writing that confidential communications about medical matters be made in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail to an alternative address. We will accommodate all reasonable requests. You do not have to provide a reason, but the request must specify how or where you wish to be contacted.

**Choose someone to act for you** – If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

**Receive a paper copy of this notice** – You can request a copy of this Notice at any time from any WPMB employee.

## CHANGES TO THIS NOTICE

MultiCare reserves the right to change this Notice. A current copy of the Notice, including the effective date, will be posted on our website at www.multicare.org and paper copies will be available at our facilities.

## QUESTIONS AND COMPLAINTS

If you have general questions about this Notice, please contact the MultiCare Privacy Office by phone: 253.459.8300 or email: compliance@multicare.org. If you believe your privacy rights have been violated, you may file a written complaint with the MultiCare Privacy Office, MultiCare, P.O. Box 5299, MS: 737-2-CCIA, Tacoma, WA 98415-

0299. If we cannot resolve your concerns, you also have the right to file a written complaint with the Secretary of the Department of Health and Human Services (HHS), Office for Civil Rights, 220 6th Avenue, MS RX-11, Seattle, WA 98121-1831. The quality of your care will not be jeopardized nor will you be penalized for filing a complaint.

# Patient Rights and Responsibilities

## PATIENT RIGHTS BY LAW

You have the right to:

- be treated and cared for with dignity and respect;
- confidentiality, privacy, security, complaint resolution, spiritual care, and communication. If communication restrictions are necessary for patient care and safety, we will document and explain the restrictions to you and your family;
- be protected from abuse and neglect;
- and have access to protective services;
- complain about your care and treatment without fear of retribution or denial of care;
- timely complaint resolution;
- be involved in all aspects of your care including:
    - Refusing care and treatment; and
    - Resolving problems with care decisions;
- information of unanticipated outcomes that will be provided to you or your family or any surrogate decision makers you have identified;
- be informed and agree to your care;
- family input in care decisions;
- have advance directives and for the hospital to respect and follow those directives;
- request no resuscitation or life-sustaining treatment;
- end of life care;
- donate organs and other tissues with:
    - Medical staff input; and
    - Direction by family or surrogate decision makers;
- a written statement of these patient rights.

### *Non-Discrimination*

Woodcreek Pediatrics – Mary Bridge Children's ("WPMB") complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

## WPMB HAS ADOPTED AND IMPLEMENTED POLICIES AND PROCEDURES

- to identify patients who are potential organ and tissue donors;
- to address research, investigation, and clinical trials including:
- how to authorize research if you choose to participate;
- require staff to follow informed consent laws; and
- not hindering your access to care if you refuse to participate in a research study.

## ADDITIONAL PATIENT RIGHTS

You have the right to:

- an interpreter, free of charge.
- know about your condition and to be told about the results of care, including unexpected ones.
- to pain management.
- understand the choices for treatment including alternatives (including no treatment), risks and benefits.
- obtain a second opinion.
- know the name and role of each person giving you care.
- know about your medications, any equipment used, and community resources you might need.
- choose whether or not you would like to participate in medical research studies. You should have complete information about the study and sign a consent if you choose to participate. If you choose not to participate, your medical care will not be negatively affected.
- have your bill explained to you.
- obtain copies of your medical records. You may do so by contacting the WPMB Health Information Management Department (medical records) at 253.848.8797.

## CONCERNS, COMPLAINTS, GRIEVANCES

If you have a concern regarding care or service provided at any WPMB location, we want to talk with you. You may file this complaint without fear of retribution or denial of care.

- Notify any staff member of your concern.
- Speak with manager directly about your concern.
- Email us at: info@woodcreekhealthcare.com
- Write us at: Woodcreek Pediatrics - Mary Bridge Children's Attn: Compliance Officer, 11102 Sunrise Blvd, Suite 103, Puyallup, WA 98374

When we receive your concern, we will send it to the right person for evaluation. If we are unable to immediately resolve your issue, we will provide a written notice within 45 days. The letter will contain:

- the name of the person responsible for evaluation;
- the basic steps taken to look into and resolve the issue; and
- the results and the date when done.

## YOU HAVE THE RIGHT TO FILE A COMPLAINT WITH THE WASHINGTON STATE DEPARTMENT OF HEALTH AT 800.633.6828 OR YOU MAY CONTACT ONE OF THE FOLLOWING

- The complaint system for the state is available online at www.atg.wa.gov/FileAComplaint.aspx
- Adult Protective Services **877.734.6277**
- Child Protective Services **800.422.7517**
- Consumer Protection Agency **800.551.4636**
- Health Facilities and Services Licensing **800.633.6828**
- Medicaid Fraud Control Unit **360.586.8888**
- State Attorney General **360.753.6200**

In addition, you may contact Qualis Health at 800.949.7536 for quality of care issues, insurance coverage decisions, or to appeal a premature discharge

*Patient Responsibilities*

- Let someone know if you don't understand what you are being told.
- Tell us everything you know about your health.
- Let someone know if there are changes in your condition.
- Participate in making decisions, following directions and accepting responsibility for your choices.
- Respect the rights and privacy of others.
- If you are unable to keep an appointment, let us know as soon as possible.
- Deal with your bill promptly and let the billing department know if you need to make special payment arrangements.
- Refer to Customer Service if you need more information or help.

### SPECIAL RIGHTS OF ADOLESCENTS

In addition to the patient rights stated above, the law provides the following rights for adolescent patients:

- A minor patient 13 years or older may consent to outpatient treatment for mental health and substance abuse issues (drugs and alcohol).
- A minor patient 14 years or older may consent to outpatient treatment for sexually transmitted diseases.
- A minor patient, regardless of age, may consent to birth control or pregnancy-related care.
- Emancipated minors may consent for their own treatment.
- If you wish to be seen for diagnosis/treatment for one of the above conditions, tell the appointment scheduler when you make your appointment and to your provider.

### MARIJUANA POLICY

Marijuana is legal for medical and recreational use in Washington State. However, possession and consumption of marijuana is still illegal under federal law. Marijuana in any form is prohibited throughout Woodcreek Healthcare facilities and grounds. This policy applies to visitors and employees.

# Understanding your Bill

Healthcare billing is complicated. Although everyone is charged the same, different insurance plans may mean that patients are responsible for paying different amounts for the same service. This is why it's critical to give the right personal and insurance information to your healthcare provider. If you get follow up questions from either your insurance plan or your health care provider, please respond as quickly as possible.

### QUESTIONS AND CONCERNS ABOUT YOUR BILL

Please contact the Woodcreek Pediatrics – Mary Bridge Children's ("WPMB") billing office at 253.848.8797 for help with:

- ✓ Applying for free or other reduced price care.
- ✓ Applying for Medicaid, Basic Health, or other public insurance programs.
- ✓ Understanding your bill.
- ✓ To discuss options for setting up a payment plan.
- ✓ Visit www.woodcreekhealthcare.com/billpay to pay your bill online

# Financial Assistance

Woodcreek Pediatrics – Mary Bridge Children's ("WPMB") is committed to serving all patients, including those who lack health insurance coverage and who cannot pay for all or part of the essential care they receive. We are committed to treating all patients with compassion. We are committed to maintaining Financial Assistance policies that are consistent with our mission and values and that take into account an individual's ability to pay for medically necessary health care services. To learn more about how our Financial Assistance Team may help you with our Financial Assistance Programs please call 253.848.8797, Monday-Friday from 8am to 5pm or visit www.MultiCare.org/financial-assistance.

### FINANCIAL ASSISTANCE POLICY

The complete Financial Assistance policy is available to you online or by phone. Please visit www.MultiCare.org/financial-assistance.

**The following information summarizes our FINANCIAL ASSISTANCE PROGRAMS.**

WPMB uses the Federal Poverty Guidelines to help determine what Financial Assistance Program best fits your needs.

### INCOME IS UP TO 300% OF FEDERAL POVERTY GUIDELINES

After a financial assessment of the patient's income has been completed, the patient's bill will be reduced by 100% if their income level is at or below 300% of the Federal Poverty Guidelines.

### INCOME IS 301 – 500% OF FEDERAL POVERTY GUIDELINES

After a financial assessment of the patient's income and assets have been completed, the patient's bill will be reduced if their income level is between 301% and 500% of the Federal Poverty Guidelines.

You can also download our Financial Assistance Eligibility grid to review current poverty level information and WPMB's income-based discounts at the following URL www.MultiCare.org/financial-assistance.