Health Information Acknowledgement and Consent

I understand that Pacific Sage LLC which also uses the name Pacific Sage Primary Care and Pacific Sage Medical Services (referred to below as "This Practice") will use and disclose health information about me.

I understand that my **health information** may include information both created and received by the practice, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that This Practice may **use and disclose** my health information to:

- Make decision about and plan for my care and treatment
- Refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment
- Determining my eligibility for health plan or insurance coverage, and submit bills, claims, and other related information to insurance companies or others who may be responsible to pay for some or all of my health care; and
- Perform various office, administrative, and business functions that support my provider's efforts to provide me with quality cost-effective health care and to arrange and be reimbursed for quality cost-effective health care.

I understand that I have the right to receive and review a written description of how This Practice will handle health information about me. This written description is known as a **Notice of Privacy Practices** and describes the uses and disclosures of health information made and the information practices followed by the employees, staff, and other office personnel of This Practice, and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy or a summary of the most current version of This Practice's Notice of Privacy Practices in effect will be posted on-line where I can access it. I can also request a copy be sent to me at home or through email.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that This Practice is not required by law to agree to such requests.

By signing below, I agree that I have reviewed and understand the information above and that I have received a copy of the Notice of Privacy Practices (see forms).

_____ _____

Patient's Signature Date

_____ _____

Authorized Representative Signature Date

_____ _____

Name of Representative Relationship

1 Informed Consent for Telemedicine Services: Ann Ottesen NP

INTRODUCTION

Telemedicine involves the use of electronic communications to enable health care providers at different locations to share individual patient medical information for the purpose of improving patient care. Providers may include primary care practitioners, specialists, and/or subspecialists. The information may be used for diagnosis, therapy, follow-up and/or education, and may include any of the following:

- Patient medical records
- Medical images
- Live two-way audio and video
- Output data from medical devices and sound and video files

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

EXPECTED BENEFITS

- Improved access to medical care by enabling a patient to remain in his/her office (or at a remote site) while the provider obtains test results and consults from healthcare practitioners at distant/other sites.
- More efficient medical evaluation and management.
- Obtaining expertise of a distant specialist.

POSSIBLE RISKS

As with any medical procedure, there are potential risks associated with the use of telemedicine. These risks include, but may not be limited to:

- In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate medical decision making by the providers and consultant(s);
- Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment;
- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information;
- In rare cases, a lack of access to complete medical records may result in adverse drug interactions or allergic reaction or other judgment error.

BY SIGNING THIS FORM, I ATTEST TO AND UNDERSTAND THE FOLLOWING:

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine,
2. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment,
3. I understand that I have the right to inspect all information obtained and recorded in the course of telemedicine interaction, and may receive copies of this information for a reasonable fee,
4. I understand that a variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time. Ann Ottesen NP has explained the alternatives to my satisfaction,
5. I understand that telemedicine may involve electronic communication of my personal medical information to other medical practitioners who may be located in other areas, including out of state.
6. I understand that it is my duty to inform Ann Ottesen NP of electronic interactions regarding my care that I may have with other healthcare providers.
7. I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured.
8. I attest that I am located in the state of Oregon and will be present in the state of Oregon during all telehealth encounters with Ann Ottesen NP.

2 Informed Consent for Telemedicine Services: Ann Ottesen NP

PATIENT CONSENT TO THE USE OF TELEMEDICINE
I have read and understand the information provided on page 1 regarding telemedicine, have discussed it with my provider, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my medical care.

I understand a copy of this form will be available for me to print.

I hereby authorize *Ann Ottesen* NP to use telemedicine in the course of my diagnosis and treatment.
By signing below, I agree to use electronic records and signatures and I acknowledge that I have read the related "consumer disclosure".

Please sign below.

_____ _____
Patient's Signature Date

_____ _____
Authorized Representative Signature Date

_____ _____
Name of Representative Relationship

Legal Consent Form

_____ _____ _____ _____/_____/_____

Patient First Name MI Last Name Date of Birth

Initial each section and sign below

____Consent to Medical Care and Treatment: I consent to all medical and surgical care, examination, and tests determined to be necessary. I understand that I have the right to refuse any procedure or treatment and I have the right to discuss all medical treatments with my clinician. Though I expect the care given will meet customary standards, I uderstand there are no guarantees concerning the results of my care. If I refuse suggested examinations, tests, or treatments against medical advice, I will not hold Pacific Sage LLC or any individual responsible for any of the consequences.

____Assignment of Benefits, Authorization to Release Medical Information: I request that payment of authorized benefits from my insurance carrier be made either to me or on my behalf to Pacific Sage LLC for any services furnished to me by Pacific Sage LLC and hereby assign Pacific Sage LLC all assignable rights to payment for services rendered by Pacific Sage LLC including all Medicare benefits if I am in that program. I authorize my insurance carrier to release information regarding my coverage to Pacific Sage LLC. I authorize any holder of medical information about me to release it to the following when applicable to determine benefits for related cservices: Centers for Medicare and Medicaide Services, insurers, and/or agents of these companies, or other helathcare providers assisting in my medical care. I understand and agree that my health inormation may be used and disclosed by Pacific Sage LLC, other providers, and insurers for treatment, payment, and health care operations pursposes. I understand that Pacific Sage LLC paricipates in an electronic medical prescribing softward (e-prescribing) and authorize Pacific Sage LLC to send prescriptions directly to a pharmacy from the point of care. I agree that Pacific Sage LLC may request and use my prescription history from other healthcare providrs or third-party payors for treatment pursposes.

____Financial Agreement: I understand that I am financially responsible for any charges regardless of insurance coverage unless I have Oregon Medicaid insurance which covers all Primary Care Services provided by Pacific Sage LLC. The maximum charge for services provided by Pacific Sage LLC that I would need to pay out of pocket regardless of insurance coverage for each visit is $250 (unless I have Oregon Medicaid insurance which covers all Primary Care Services). I agree to pay up to $250 for services provided by Pacific Sage LLC for each visit (unless I have Oregon Medicaid Insurance). There may be additional charges from other entities that provide services ordered by Pacific Sage LLC, but those entities will collect payment(s) independently.

____Consent to Text Messaging and email: In order to enhance patient care and experience, Pacific Sage LLC may contact me via phone call, voicemail, SMS text message, email, or mobile application, some of which may be via automated means to remind me of an appointment, to obtain feedback on my experience with our healthcare team, and to provide general health reminders/information. I understand and agree to be contacted in this manner with communications related to this visit, and any future visits. In the future, I may opt-out of

receiving text messages by notifying Pacific Sage LLC in writing. Standard telephone minute and text charges may apply if Pacific Sage LLC contacts me.

____Acknowledgement of Notice of Privacy Practices and Patient Record of Disclosures: I acknowledge that I have received a copy of Pacific Sage LLC's Notice of Privacy Practices. In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that communication of PHI is made by alernative means, such as sending correspondence to the indivicual's office instead of the individual's home.

____Video Surveillance for Security and healthcare Operations: I understand and consent to video surveillance for security purposes and/or Pacific Sage LLC's health care operations. I understand that the facility retains the ownership rights to images and/or recordings. I understand these images and/or recordings will be securely stored and protected.

____By signing below, I hereby understand and agree with the above information and understand that my refusal to sign this form will be interpreted as my decision to cease receiving medical care with Pacific Sage LLC, which also goes by the names of Pacific Sage Primary Care and Pacific Sage Medical Services.

_____ _____

Patient's Signature Date

_____ _____

Authorized Representative Signature Date

_____ _____

Name of Representative Relationship

Consent to Communicate: Pacific Sage LLC

_____ ____ _____ ___/___/_____ ___/___/_____
First Name MI Last Name Date of Birth Date

Consent for leaving messages: I understand that my healthcare information is protected. In order for Pacific Sage LLC to leave detailed messages containing specific health information on my voicemail or answering machine, I need to give permission to do so.

I give permission to Pacific Sage LLC for messages to be left on the phone number(s) listed below:

Phone: _____ Phone: _____Phone: _____
Messages may be left regarding the following:

- ☐ Appointment Reminders/Changes
- ☐ Account Payments/Balances
- ☐ Cost Estimates
- ☐ Medical Treatment (Needed/Completed)

Consent to verbally share information: By completing the information and signing below, I authorize Pacific Sage LLC to **verbally discuss** my medical care and other protected information. The name(s) listed below are individuals to whom I grant permission for Practice representatives to verbally discuss information using their best judgment that is relevant to my care or relevant to payment for such care.

1. Name: _____ Phone: _____ Relationship to patient: _____

May be contacted regarding the following:

- ☐ Appointment reminders/changes
- ☐ Account payments/balances
- ☐ Cost estimates
- ☐ Medical information/Care/Treatments needed or completed
- ☐ Sensitive medical information including:
  - ☐ Sexually Transmitted Infections, HIV/AIDs
  - ☐ Substance use including drugs and alcohol
  - ☐ Mental health conditions

2. Name: _____ Phone: _____ Relationship to patient: _____

May be contacted regarding the following:

- ☐ Appointment reminders/changes
- ☐ Account payments/balances
- ☐ Cost estimates
- ☐ Medical information/Care/Treatments needed or completed
- ☐ Sensitive medical information including:
  - ☐ Sexually Transmitted Infections, HIV/AIDs
  - ☐ Substance use including drugs and alcohol
  - ☐ Mental health conditions

3. Name: _____ Phone: _____ Relationship to patient: _____

May be contacted regarding the following:

- ☐ Appointment reminders/changes
- ☐ Account payments/balances
- ☐ Cost estimates
- ☐ Medical information/Care/Treatments needed or completed
- ☐ Sensitive medical information including:
  - ☐ Sexually Transmitted Infections, HIV/AIDs
  - ☐ Substance use including drugs and alcohol
  - ☐ Mental health conditions

It will be my responsibility to keep this information up to date as I recognize relationships may change over time. This consent will be considered valid until I revoke it in writing. I reserve the right to revoke it at any time. I understand revoking this authorization will not affect disclosures made or actions taken before revocation is received.

_____ _____
Patient's Signature Date

U.S. Department of Transportation
Federal Motor Carrier
Safety Administration

Medical Examination Report Form
(for Commercial Driver Medical Certification)

MEDICAL RECORD #

_____

(or sticker)

SECTION 1. Driver Information *(to be filled out by the driver)*

PERSONAL INFORMATION

Last Name: _____ First Name: _____ Middle Initial: ___ Date of Birth: _____ Age: ___

Street Address: _____ City: _____ State/Province: _____ Zip Code: _____

Driver's License Number: _____ Issuing State/Province: _____ Phone: _____

E-Mail *(optional)*: _____ CLP/CDL Applicant/Holder*: ◯ Yes ◯ No

Driver ID Verified By**: _____

Has your USDOT/FMCSA medical certificate ever been denied or issued for less than 2 years? ◯ Yes ◯ No ◯ Not Sure

*CLP/CDL Applicant/Holder: See instructions for definitions.

**Driver ID Verified By: Record what type of photo ID was used to verify the identity of the driver, e.g., CDL, driver's license, passport.

DRIVER HEALTH HISTORY

Have you ever had surgery? If "yes," please list and explain below. ◯ **Yes** ◯ **No** ◯ **Not Sure**

Are you currently taking medications *(prescription, over-the-counter, herbal remedies, diet supplements)*? If "yes," please describe below. ◯ **Yes** ◯ **No** ◯ **Not Sure**

(Attach additional sheets if necessary)

This document contains sensitive information and is for official use only. Improper handling of this information could negatively affect individuals. Handle and secure this information appropriately to prevent inadvertent disclosure by keeping the documents under the control of authorized persons. Properly dispose of this document when no longer required to be maintained by regulatory requirements.

Last Name: _____ First Name: _____ DOB: _____ Exam Date: _____

DRIVER HEALTH HISTORY *(continued)*

Do you have or have you ever had:	Yes	No	Not Sure
1. Head/brain injuries or illnesses *(e.g., concussion)*	○	○	○
2. Seizures/epilepsy	○	○	○
3. Eye problems *(except glasses or contacts)*	○	○	○
4. Ear and/or hearing problems	○	○	○
5. Heart disease, heart attack, bypass, or other heart problems	○	○	○
6. Pacemaker, stents, implantable devices, or other heart procedures	○	○	○
7. High blood pressure	○	○	○
8. High cholesterol	○	○	○
9. Chronic (long-term) cough, shortness of breath, or other breathing problems	○	○	○
10. Lung disease *(e.g., asthma)*	○	○	○
11. Kidney problems, kidney stones, or pain/problems with urination	○	○	○
12. Stomach, liver, or digestive problems	○	○	○
13. Diabetes or blood sugar problems	○	○	○
Insulin used	○	○	○
14. Anxiety, depression, nervousness, other mental health problems	○	○	○
15. Fainting or passing out	○	○	○
16. Dizziness, headaches, numbness, tingling, or memory loss	○	○	○
17. Unexplained weight loss	○	○	○
18. Stroke, mini-stroke (TIA), paralysis, or weakness	○	○	○
19. Missing or limited use of arm, hand, finger, leg, foot, toe	○	○	○
20. Neck or back problems	○	○	○
21. Bone, muscle, joint, or nerve problems	○	○	○
22. Blood clots or bleeding problems	○	○	○
23. Cancer	○	○	○
24. Chronic (long-term) infection or other chronic diseases	○	○	○
25. Sleep disorders, pauses in breathing while asleep, daytime sleepiness, loud snoring	○	○	○
26. Have you ever had a sleep test *(e.g., sleep apnea)*?	○	○	○
27. Have you ever spent a night in the hospital?	○	○	○
28. Have you ever had a broken bone?	○	○	○
29. Have you ever used or do you now use tobacco?	○	○	○
30. Do you currently drink alcohol?	○	○	○
31. Have you used an illegal substance within the past two years?	○	○	○
32. Have you ever failed a drug test or been dependent on an illegal substance?	○	○	○

Other health condition(s) not described above: ○ Yes ○ No ○ Not Sure

Did you answer "yes" to any of questions 1-32? If so, please comment further on those health conditions below: ○ Yes ○ No ○ Not Sure

(Attach additional sheets if necessary)

CMV DRIVER'S SIGNATURE

I certify that the above information is accurate and complete. I understand that inaccurate, false or missing information may invalidate the examination and my Medical Examiner's Certificate, that submission of fraudulent or intentionally false information is a violation of 49 CFR 390.35, and that submission of fraudulent or intentionally false information may subject me to civil or criminal penalties under 49 CFR 390.37 and 49 CFR 386 Appendices A and B.

Driver's Signature: _____ Date: _____

SECTION 2. Examination Report *(to be filled out by the medical examiner)*

DRIVER HEALTH HISTORY REVIEW

Review and discuss pertinent driver answers and any available medical records. Comment on the driver's responses to the "health history" questions that may affect the driver's safe operation of a commercial motor vehicle (CMV).

(Attach additional sheets if necessary)

Instructions for Completing the Medical Examination Report Form (MCSA-5875)

I. Step-By-Step Instructions

Driver:

Section 1: Driver Information

- **Personal Information:** Please complete this section using your name as written on your driver's license, your current address and phone number, your date of birth, age, driver's license number and issuing state.
    - **CLP/CDL Applicant/Holder:** Check "yes" if you are a commercial learner's permit (**CLP**) or commercial driver's license (**CDL**) holder, or are applying for a CLP or CDL. CDL means a license issued by a State or the District of Columbia which authorizes the individual to operate a class of a commercial motor vehicle (**CMV**). A CMV that requires a CDL is one that: (1) has a gross combination weight rating or gross combination weight of 26,001 pounds or more inclusive of a towed unit with a gross vehicle weight rating (**GVWR**) or gross vehicle weight (**GVW**) of more than 10,000 pounds; or (2) has a GVWR or GVW of 26,001 pounds or more; or (3) is designed to transport 16 or more passengers, including the driver; or (4) is used to transport either hazardous materials requiring hazardous materials placards on the vehicle or any quantity of a select agent or toxin.
    - **Driver ID Verified By:** The Medical Examiner/staff completes this item and notes the type of photo ID used to verify the driver's identity such as, commercial driver's license, driver's license, or passport, etc.
    - **Has your USDOT/FMCSA medical certificate ever been denied or issued for less than two years?** Please check the correct box "yes" or "no" and if you aren't sure check the "not sure" box.
- **Driver Health History:**
    - **Have you ever had surgery:** Please check "yes" if you have ever had surgery and provide a written explanation of the details (type of surgery, date of surgery, etc.)
    - **Are you currently taking medications (prescription, over-the-counter, herbal remedies, diet supplements):** Please check "yes" if you are taking any diet supplements, herbal remedies, or prescription or over the counter medications. In the box below the question, indicate the name of the medication and the dosage.
    - **#1-32:** Please complete this section by checking the "yes" box to indicate that you have, or have ever had, the health condition listed or the "No" box if you have not. Check the "not sure" box if you are unsure.
    - **Other Health Conditions not described above:** If you have, or have had, any other health conditions not listed in the section above, check "Yes" and in the box provided and list those condition(s).
    - **Any yes answers to questions #1-32 above:** If you have answered "yes" to any of the questions in the Driver Health History section above, please explain your answers further in the box below the question. For example, if you answered "yes" to question #5 regarding heart disease, heart attack, bypass, or other heart problem, indicate which type of heart condition. If you checked "yes" to question #23 regarding cancer, indicate the type of cancer. Please add any information that will be helpful to the Medical Examiner.
- **CMV Driver Signature and Date:** Please read the certification statement, sign and date it, indicating that the information you provided in Section 1 is accurate and complete.

Additional CDL Exam Intake Info

Name _____ Date of Birth _____ Date _____

How did you hear about us? _____

Do you have any allergies to Meds?

☐ yes ☐ no

Allergy: _____

Reaction:_____

Allergy: _____

Reaction:_____

Allergy: _____

Reaction: _____

Allergy: _____

Reaction: _____

Do you have any allergies to foods or other substances?

☐ yes ☐ no

Allergies: _____

_____

Do you snore loudly? (Louder than talking or loud enough that you can be heard through closed doors)

☐ yes ☐ no

Do you often feel tired, fatigued, or sleepy during the daytime?

☐ yes ☐ no

Has anyone observed you stop breathing, gasp, or choke while sleeping?

☐ yes ☐ no

If you were REALLY TIRED and driving, what would you do to be safe? (pick the BEST answer)

- ☐ Pull over and rest
- ☐ Keep driving and hope you don't nod off
- ☐ Listen to soothing music
- ☐ Turn up the heat

Do you know your family medical history?

☐ yes ☐ no

If yes, Mark all that apply:

- ☐ Diabetes
- ☐ Asthma
- ☐ Coronary Artery Disease
- ☐ Heart Attack-MI
  - Before age 60? ☐ Yes ☐ No
- ☐ Stroke or TIA (mini stroke)
  - Before age 60? ☐ Yes ☐ No
- ☐ Chronic Kidney Disease
- ☐ Suicide attempts
- ☐ Mental illness besides anxiety or depression
- ☐ Autoimmune disease
  - ☐ Type I diabetes (onset usually very young)
  - ☐ Rheumatoid arthritis
  - ☐ Celiac disease
  - ☐ Lupus
  - ☐ Grave's disease (thyroid)
  - ☐ Hashimoto's thyroiditis (thyroid)
  - ☐ Multiple sclerosis
  - ☐ Inflammatory bowel disease
  - ☐ Myasthenia gravis
  - ☐ Addison's Disease
  - ☐ Sjogren's syndrome
- ☐ Cancer (specify)
  - ☐ Bladder
  - ☐ Brain
  - ☐ Breast
  - ☐ Colon
  - ☐ Kidney
  - ☐ Lung
  - ☐ Melanoma
  - ☐ Pancreas
  - ☐ Prostate
  - ☐ Other _____
- ☐ Other Medical Problems: _____