I Ola Lāhui, Inc.

1441 Kapiʻolani Boulevard, Suite 1441, Honolulu, Hawaiʻi 96814
Phone: (808) 525-6255 Fax: (808) 525-6256

Clinic Locations:

Ala Moana Building	Aiea Medical Building	Kahuku Medical Center
1441 Kapi ʻolani Blvd., Suite 1802 Honolulu, HI 96814	99-128 Aiea Heights Drive, Suite 202 Aiea, HI 96701	56-117 Pualalea St. Plantation Wing #17 Kahuku HI, 96731

NEW PATIENT INFORMATION SHEET

Patient Information

Name: _____ Social Security: ____-_____-_____

Age: _____ Date of Birth: _____ Gender: _____

Marital Status: □ Single □ Married □ Separated □ Divorced □ Widowed

Address: _____

City/State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email: _____ Are you a Veteran of the United States military? □ Yes □ No

Employment Status: □ Full Time □ Part Time □ Retired □ Not Employed

Occupation: _____ Employer: _____

Referral Source: _____ Primary Care Physician: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Insurance Information

- Primary Insurance Company: _____

  Subscriber Name: _____ Subscriber DOB: _____

  Subscriber #: _____ Group #: _____

- Secondary Insurance Company: _____

  Subscriber Name: _____ Subscriber DOB: _____

  Subscriber #: _____ Group #: _____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with the insurance company listed above and assign directly to I Ola Lāhui all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not they are paid by the insurance company. I hereby authorize I Ola Lāhui to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I will notify I Ola Lāhui of any changes in the above information.

_____	_____	_____
Responsible Party Signature	**Relationship to Patient (if not signed by patient)**	**Date**

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Honolulu, HI 96814	Aiea, HI 96701	Plantation Wing #17
		Kahuku HI, 96731

Informed Consent for Treatment/Authorization Form

Consent for Treatment

I hereby agree and consent to take part in treatment with my provider, and I understand that while I expect benefits from this treatment, results are not guaranteed. I understand that I have the right to refuse treatment and discontinue at any time without moral, legal or financial obligation. If I choose, I will be provided with referrals for other qualified providers within the community. If my provider is unavailable, I understand that every effort will be made to inform me in advance, and alternative coverage will be provided.

I understand that I will be advised of the risks of any unusual procedures, and I have the right to refuse unwanted therapeutic techniques. I have the right to refuse electronic media recording of any session and that this will not occur without my prior written consent. I understand the limits of confidentiality as they have been explained to me by my provider.

I have had the opportunity to discuss all the aspects of my treatment and have had my questions answered. I understand the parameters of treatment and understand the regular attendance will produce maximum possible benefits. I agree to comply with treatment planned.

Confidentiality

Behavioral health services are provided within I Ola Lāhui by providers with varying backgrounds, including pre-doctoral interns, post-doctoral fellows and licensed psychologists. Services rendered by paraprofessionals are supervised by their respective licensed provider(s). Your service provider should identify his or her professional status and clarify with you the nature of this, the individual providing supervision and discuss any concerns you may have regarding your care.

I understand records about my care will be kept in written or computerized form and will be available to all providers participating in my overall care and treatment. All providers within I Ola Lāhui insure confidentiality of the disclosed information by their patients within the limits outlined below. In most cases, your written consent must be obtained prior to the release of any patient information. There are, however, circumstances in which your provider may be required by law to disclose information pertaining to your treatment to the authorities without your written consent. Your provider should inform you of such actions.

In general, the law protects the confidentiality of all communications between a client and a therapist, and the release of information to others about your therapy only with your written permission (see **Release of Medical Records**). However, there are exceptions where:

- Client is a danger to self / others

- Abuse or neglect of a child, elderly or disabled person
- Specific court cases or proceedings

Release of Medical Records

Authorized release of your medical records to other entities requires written consent in the form of a Release of Medical Records. However, in order to ensure proper follow-up and continuity of care, I agree that a brief summary including the nature and length of treatment may be released to my referring provider.

Insurance Authorization

I request that payment of authorized benefits be made to I Ola Lāhui on my behalf, for any services provided to me. I authorize any holder of medical and other information about me to release to Medicare and its agents, any insurance company, any other third-party payer, state medical assistance agency, or any other government or private payer responsible for paying such benefits, any information needed to determine these benefits or benefits for related services. I agree to pay for all the charges not covered by a third-party payer. I authorize a copy of this authorization to be used in place of the original.

I have read the above and understand the nature of services provided, the limits of confidentiality and release of my medical records, and charges for services.

Name of Patient: _____

Signature of Patient/Parent/Guardian: _____ Date: _____

Psychologist Signature: _____ Date: _____

HEALTH HISTORY

Full Name: _____ Gender: _____

Date of Birth: _____ Age: _____

What is your ethnic background? (Please check ALL that apply)

□ Native Hawaiian
□ Micronesian
□ Samoan
□ Tongan
□ Filipino
□ Japanese
□ Chinese
□ Mexican
□ Puerto Rican
□ African American
□ Caucasian
□ Other:

What ethnicity do you most identify with? _____

What is the highest degree or level of school you have completed? If currently enrolled, mark the previous grade or highest degree received.

□ No schooling completed
□ Grade School (K-8)
□ Some high school
□ High school graduate- high school diploma, or equivalent
□ Some college credit, but less than 1 year
□ 1 or more years of college, no degree
□ Technical Degree
□ Associate degree
□ Bachelor's degree
□ Master's degree
□ Professional degree
□ Doctorate degree
□ Other: _____

What is your occupation? _____

Who do you currently live with? _____

MILITARY AFFILIATION:

Is any member of your family in the military?

□ No (skip to MEDICAL HISTORY) **□ Yes (see below)**

If yes, please check all affiliations:	**ACTIVE DUTY**					**NATIONAL GUARD**	**RESERVES**	**VETERAN**
	Air Force	Army	Coast Guard	Marines	Navy			
Myself								
Spouse								
Parent								
Other Family Member: _____ _____								

MEDICAL HISTORY:

Current Health Status: _____

Select the following conditions that you currently have or have had in the past:

□ Recurrent headaches
□ Eye problems
□ Ear problems
□ Nose problems
□ Throat problems
□ Thyroid disorder
□ Heart murmur
□ Heart disease
□ Heart palpitations
□ High blood pressure
□ Low blood pressure
□ Anemia
□ Bleeding disorders/Hemophilia
□ Hepatitis
□ Kidney disorders
□ Bladder disorders
□ Pneumonia
□ Bronchitis
□ Epilepsy
□ Seizures
□ Dizziness
□ Fainting with exercise
□ Head injury
□ Concussion
□ Bone injuries
□ Joint injuries
□ Stomach problems
□ Intestinal problems
□ Diabetes
□ Eating disorder
□ Tuberculosis
□ Chicken pos illness
□ Mononucleosis
□ Seasonal Allergies/Hay fever
□ Asthma
□ Other: _____

List any medical hospitalizations or surgeries and dates: _____

_____

List any current medications you are taking (include dosage): _____

_____

Please list any medications you are allergic to: _____

HEALTH HABITS:

Sleep: Do you have difficulty falling or staying asleep? □ Yes □ No

About how many hours of sleep do you get per night? _____

About how many times a night do you wake up? _____

Substances: Do you currently use any of the following:

□ Caffeine (Cups/day: _____)
□ Tobacco (Cig/day: _____)
□ Alcohol (Drinks/wk: _____)
□ Other substances/illicit drugs (Type/amt: _____)

PSYCHOLOGICAL HISTORY:

Do you have any history of:

□ Physical abuse □ Sexual Abuse □ Domestic Violence

Have you ever seen a counselor or therapist before? □ Yes □ No

If so, dates of previous therapy: _____

Name of previous therapist: _____

Are you currently seeing a psychiatrist? □ Yes □ No

If so, name of psychiatrist: _____

Please list any previous psychiatric hospitalizations (date and length of hospitalization:

_____

Have you ever received alcohol or substance abuse treatment: □ Yes □ No

If so, name of program and dates attended: _____

PRAPARE

Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences

1. At any point in the past 2 years, has season or migrant farm work been your or your family's main source of income?

◯	Yes	◯	No	◯	I choose not to answer this question

2. What language are you most comfortable speaking?

◯	English
◯	Language other than English (please write)
◯	I choose not to answer this question

3. How many family members, including yourself, do you currently live with? _____

☐	I choose not to answer this question

4. What is your zip code: _____

5. What is the highest level of school that you have finished?

◯	Less than high school degree	◯	High school diploma or GED
◯	More than high school	◯	I choose not to answer this question

6. What is your housing situation today?

◯	I have housing
◯	I do not have housing (staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, or in a park)
◯	I choose not to answer this question

7. Are you worried about losing your housing?

◯	Yes	◯	No	◯	I choose not to answer this question

8. What is your current work situation?

◯	Unemployed	◯	Part-time or temporary work	◯	Full-time work
◯	Otherwise unemployed but not seeking work (ex: student, retired, disabled, unpaid primary care giver) Please write:				
◯	I choose not to answer this question				

9. During the past year, what was the total combined income for you and the family members you live with? This information will help us determine if you are eligible for any benefits.

_____

☐	I choose not to answer this question

10. Do you feel physically and emotionally safe where you currently live?

◯	Yes	◯	No	◯	Unsure
◯	I choose not to answer this question				

11. In the past year, have you or any family members you live with been **unable** to get any of the following when it was **really needed**? Check all that apply.

◯	Yes ◯ No	Food	◯	Yes ◯ No	Clothing		
◯	Yes ◯ No	Utilities	◯	Yes ◯ No	Child Care		
◯	Yes ◯ No	Medicine or Any Health Care (Medical, Dental, Mental Health, Vision)					
◯	Yes ◯ No	Phone	◯	Yes ◯ No	Other (please write):		
☐	I choose not to answer this question						

12. Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living? Check all that apply.

◯	Yes, it has kept me from medical appointments or from getting my medications
◯	Yes, it has kept me from non-medical meetings, appointments, work, or from getting things that I need
◯	No
◯	I choose not to answer this question

PRAPARE

Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences

13. How often do you see or talk to people that that you care about and feel close to? (For example: talking to friends on the phone, visiting friends or family, going to church or club meetings)

○ Less than once a week	○ 1 or 2 times a week
○ 3 to 5 times a week	○ 5 or more times a week
○ I choose not to answer this question	

14. Stress is when someone feels tense, nervous, anxious, or can't sleep at night because their mind is troubled. How stressed are you?

○ Not at all	○ A little bit
○ Somewhat	○ Quite a bit
○ Very much	○ I choose not to answer this question

15. In the past year, have you spent more than 2 nights in a row in a jail, prison, detention center, or juvenile correctional facility?

○ Yes	○ No	○ I choose not to answer this question

16. Are you a refugee?

○ Yes	○ No	○ I choose not to answer this question

17. In the past year, have you been afraid of your partner or ex-partner?

○ Yes	○ No	○ Unsure
○ I have not had a partner in the past year		
○ I choose not to answer this question		

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Name: _____ **Date:** _____

Over the last two weeks, how often have you been bothered by any of the following problems:

	Not at all (0)	Several days (1)	More than half the days (2)	Nearly every day (3)
1. Little interest or pleasure in doing things	☐	☐	☐	☐
2. Feeling down, depressed or hopeless	☐	☐	☐	☐
3. Trouble falling asleep or staying asleep, or sleeping too much	☐	☐	☐	☐
4. Feeling tired or having little energy	☐	☐	☐	☐
5. Poor appetite or overeating	☐	☐	☐	☐
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
7. Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	☐	☐	☐	☐
9. Thoughts that you would be better off dead, or of hurting yourself	☐	☐	☐	☐

10. If you checked off *any problems*, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

- □ Not difficult at all
- □ Somewhat difficult
- □ Very difficult
- □ Extremely difficult

SF-12 Health Survey

Name: _____ Date of Birth: _____

Today's Date: _____

Please answer every question. Some questions may look like others, but each one is different. Please take the time to read and answer each question carefully by circling the number that best represents your response.

1. In general, would you say your health is:

1) Excellent ☐ 2) Very Good ☐ 3) Good ☐ 4) Fair ☐ 5) Poor ☐

2. The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

	Yes, limited a lot	Yes, limited a little	No, not limited
a. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf?	1 ☐	2 ☐	3 ☐
b. Climbing several flights of stairs?	1 ☐	2 ☐	3 ☐

3. During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
a. Accomplished less than you would like	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
b. Were limited in the kind of work or other activities	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐

4. During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
a. Accomplished less than you would like	1 ☐	2 ☐	3 ☐	4 ☐	☐
b. Did work or other activities less carefully than usual	1 ☐	2 ☐	3 ☐	4 ☐	☐

5. During the past 4 weeks, how much did pain interfere with your normal work (including both work, outside the home, and housework)?

1) Not at all ☐ 2) A little bit ☐ 3) Moderately ☐ 4) Quite a bit ☐ 5) Extremely ☐

6. These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the past 4 weeks...

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
a. Have you felt calm and peaceful?	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
b. Did you have a lot of energy?	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
c. Have you felt downhearted and depressed?	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐

7. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)?

1) All of the time ☐ 2) Most of the time ☐ 3) Some of the time ☐ 4) A little of the time ☐ 5) None of the time ☐

ABOUT I OLA LĀHUI TELEHEALTH SERVICES

Mahalo for choosing telehealth services with I Ola Lāhui (IOL). Telehealth means using a computer, smart phone, or telephone to meet with your provider instead of coming in-person for appointments. You will see your provider on video and be able to talk comfortably and privately with them just as you would if you came into our office.

- We agree to use the telehealth platform (i.e., Zoom video or phone) for our sessions. Your provider will explain how to use it.
- There are potential benefits and risks of telehealth that are different from in-office. We use Zoom which is secure and HIPAA compliant to protect your privacy.
- Confidentiality still applies for telehealth services.
    - Nobody will record the session without the permission.
    - A private space is ideal to prevent others from hearing information you share during your session.
    - Use a secure internet connection rather than public/free Wi-Fi.
- If you are not an adult, we need the permission of your parent or legal guardian (and their contact information) for you to participate in telehealth sessions.

Communicating with your Provider

- You may contact your I Ola Lāhui psychology team via office (808-525-6255), fax (808-525-6256), and/or email.
- If you need to cancel or change your tele-appointment, you must notify us in advance by phone (808)525-6255 or email.
- Email addresses are unencrypted and thus, non-secure. There is a limit to the amount and type of information sent via email. I Ola Lāhui email addresses are for routine communication only (i.e., scheduling appointments) and are not monitored after hours.
- For emergencies, please call 911 or the Crisis Line
    - 808-832-3100 [O ʻahu]
    - 1-800-753-6879 [Neighbor Islands]

Preparing for Your Session

- You will need to use a computer with camera capability or smartphone during session.
- It is important to be in a quiet, private space that is free of distractions (including cell phone or other devises) during the session.
- It is important to be on time. When you join the meeting, you will be put in a Waiting Room until your provider is ready to begin the appointment.
- We need a back-up phone number where you can be reached to restart the session or to reschedule it, in the event of technical problems.
- We need a safety plan that includes at least one emergency contact and the closest ER to your location, in the event of a crisis situation.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION FOR

I Ola Lāhui, Inc.

I have read the Notice of Uses and Disclosures of Protected Health Information (the "Notice) that is attached. I was informed that I may also obtain a printed copy of the Notice from my healthcare provider.

_____

Name (Print)

_____

Signature

_____

Date

I have been given the opportunity to read the notice of the Notice of Uses and Disclosures of Protected Health Information (the "Notice") that is posted in your office. I elect to decline the opportunity to do so. I was informed that I may obtain a printed copy of this Notice from my healthcare provider.

_____

Name (Print)

_____

Signature

_____

Date

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH INFORMATIONABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUAL HEALTH INFORMATION.

PLEASE READ AND REVIEW THIS NOTICE CAREFULLY.

Effective April 14, 2003

The following is the privacy policy of our office as described in the Health Insurance Portability and Accountability Act of 1996 and regulations promulgated thereunder, commonly known as HIPAA. We are required by law to maintain the confidentiality of information that identifies you. Also, we are required to provide you with this notice of privacy practices that we maintain concerning your **Protected Health Information (PHI).** We also must follow the terms of the notice of privacy practices that we have in effect at the time. We reserve the right to make changes in our privacy practices regarding you PHI. If we change our privacy practices, that change will apply to all PHI that we maintain about you. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

Your Protected Health Information

We collect personal health information from you through treatment, payment and related healthcare operations, the application and enrollment process, and/or healthcare providers or health plans, or through other means, as applicable. Your personal health information that is protected by law broadly includes any information, oral, written or recorded, that is created or received by certain health care entities, including health care providers, such as physicians and hospitals, as well as, helath insurance companies or plans. The law specifically protects health information that contains data, such as your name, address, social security number, and others, that could be used to identify you as the individual patient who is associated with that health information.

IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

I Ola Lāhui

1441 Kapiʻolani Blvd., Suite 1802

Honolulu, HI 96814

Phone: 808-525-6255

Uses or Disclosures of Your Personal Health Information

Generally, we may not use or disclose your personal health information without your permission. Further, once your permission has been obtained, we must use or disclose your personal health information in accordance with the specific terms of that permission. The following are the circumstances under which we are permitted by law to use or disclose your personal health information.

Without Your Consent: Without your consent, we may use or disclose your personal health information in order to provide you with services and the treatment you require or request, or to collect payment for those service, and to conduct other related health care operations otherwise permitted or required by law. Also, we are permitted to disclose your personal health information within and among our workforce in order to accomplish these same purposes. However, even with your permission, we are still required to limit such uses or disclosure to the minimal amount of personal health information that is reasonably required to provide those services or complete those activities.

1. **Examples of treatment activities include:** (a) the provision, coordination, or management of health care and related services by health care providers; (b) consultation between health care providers relating to a patient; or (c) the referral of a patient for health care from one health care provider to another.
2. **Examples of payment activities include:** (a) billing and collection activities and related data processing; (b) actions by a health plan or insurer to obtain premiums or to determine or fulfill its responsibilities for coverage and provision of benefits under its health plan or insurance agreement, determinations of eligibility or coverage, adjudication or subrogation of health benefit claims; (c) medical necessity and appropriateness of care reviews, utilization review activities; and (d) disclosure to consumer reporting agencies of information relating to collections of premiums or reimbursement.
3. **Examples of health care operations include:** (a) development of clinical guidelines; (b) contacting patients with information about treatment alternatives or communications in connection with case management or care coordination; (c) reviewing the qualifications of and training health care professionals; (d) underwriting and premium rating; (e) medical review, legal services, and auditing functions; and (f) general administrative activities such as customer service and data analysis.

As Required By Law

We may use or disclose your personal health information to the extent that such use or disclosure is required by law and the use or disclosure complies with and is limited to the relevant requirements of such law. In each of these situations we will keep records that explain our attempt to obtain your consent and the reason why consent was obtained. *Examples of instances in which we are required to disclose your personal health information include:*

1. **Public Health Risks.** Our practice may disclose your PHI to public health authorities that are authorities that are authorized by law to collect information for purposes such as, preventing or controlling disease or other injury, public health surveillance or investigations, reporting adverse events with respect to food or dietary supplements or

product defects or problems to the Food and Drug Administration, medical surveillance of the workplace or to evaluate whether the individual has a work-related illness or injury in order to comply with Federal or state law.

2. **Reporting Abuse.** Our practice may disclose your PHI to report disclosures regarding victims of abuse, neglect, or domestic violence to social service or protective services agencies.
3. **Health Oversight Activities.** Our practice may disclose your PHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, audits, civil, administrative, or criminal investigations, inspections, licensure or disciplinary actions, or civil, administrative, or criminal proceedings or actions, or other activities necessary for appropriate oversight of government benefit programs.
4. **Lawsuits and Similar Proceedings.** Our practice my use and disclose your PHI in response to a court or administrative order, including judicial and administrative proceedings in response to an order of a court or administrative tribunal, a warrant, subpoena, discovery request, or other lawful process;
5. **Law Enforcement.** We may release PHI is asked to do so by a law enforcement official for the purpose of identifying or locating a suspect, fugitive, material witness, or missing person, or reporting crimes in emergencies, or reporting a death.
6. **Research.** Our practice may use your PHI for certain research purposes under certain conditions.
7. **Serious Threats to Health or Safety.** Our practice may use and disclose your PHI when necessary to avert a serious threat to health or safety;
8. **Military.** Our practice may disclose your PHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
9. **National Security.** Our practice may disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.
10. **Inmates**. Our practice may disclose PHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
11. **Worker's Compensation.** Our practice may release your PHI for workers' compensation and similar programs.

<u>All Other Situations, With Your Specific Authorization</u>

Except as otherwise permitted or required as described above, we may not use or disclose your personal health information without your written authorization. Further, we are required to use or disclose your personal health information consistent with the terms of your authorization. You may revoke your authorization to use or disclose any personal health information at any time, except to the extent that we have taken action in reliance on such authorization, or, is you provided the authorization as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy.

<u>Reminders and Treatment Alternatives:</u>

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Your Rights With Respect to Your Personal Health Information

Under HIPAA, you have certain rights with respect to your personal health information. The following is a brief overview of your rights and our duties with respect to enforcing those rights.

1. **Requesting Restrictions.** You have the right to request restrictions on certain uses and disclosures of your PHI for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your PHI to only certain individuals involved in your care, such as family members and friends. We are not required to agree t your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. While we are not required to agree to any requested restriction, if we agree to a restriction, we are bound not to use or disclose your personal healthcare information in violation of such restriction, except in certain emergency situations. In order to request a restriction in our use or disclosure of your PHI, you must make your request in writing to the identified Privacy Officer.
2. **Confidential Communications.** You have the right to request that our practice talk to you about your health and related issues in a particular manner or at a certain location. For instance, you may want to be contacted at your work place, instead of home. In order to request a type of confidential communication, you must make a written request to the Privacy Officer specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate any reasonable request.
3. **Inspection and Copies.** Your designated record set is a group of records we maintain that includes Medical records and billing records about you, or enrollment, payment, claims adjudication, and case or medical management records systems, as applicable. You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about you, *except for* (a) psychotherapy notes, (b) information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding, and (c) health information maintained by us to the extent which the provision of access to you would be prohibited by law. You must submit your request in writing to the Privacy Officer. We may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. We reserve the right to deny you access to and copies of certain personal health information as permitted or required by law. Upon denial of a request for access or request for information, we will provide you with a written denial specifying the legal basis for denial, a statement of your rights, and a description of how you may file a complaint with us. Except in cases where the PHI is not maintained or accessible on-site, we will act on a request no later than thirty (30) days after we receive you request.
4. **Amendment.** You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to the Privacy Officer. You must provide us with a reason that supports your rest for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we

may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the PHI kept by or for the practice; (c) not part of the PHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information. We will act upon your request within sixty (60) days after we receive your request.

5. **Accounting of Disclosures.** You have a right to receive an accounting of all our disclosures of your PHI in the six years prior to the date of your request, except for disclosures: (a) to carry out treatment, payment and health care operations; (b) to you; (c) for our directory or to persons involved in your care; (d) for national security or intelligence purposes; (e) to correctional institutions or law enforcement officials; (f) pursuant to any written authorizations that you give to us; or (g) that occurred prior to April 14, 2003. We will provide the first accounting to you in any twelve (12) month period without charge, but will impose a reasonable cost-based fee for responding to each subsequent request for accounting within the same twelve (12) month period.
6. **Right to a Paper Copy of this Notice.** You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time.
7. **Right to File a Complaint.** If you believe that we have violated your privacy rights, then you may file a written complaint with I Ola Lāhui, Inc.. You may also file a complaint with the Office for Civil Rights of the Department of Health and Human Services. Your complaint must: (a) be in writing, either on paper or electronically; (b) name the Company and describe the acts or omissions you believed to be in violation of the Privacy Rules; (c) be filed within 180 days of when you knew, or should have known that the act or omission complained of occurred; unless the time limit is waived by the DHHS for good cause shown. The complaint may be sent to: Office of Civil Rights, U.S. Department of Health and Human Services, Region IX, 50 United Nations Plaza, Room 322, San Francisco, CA 94102. We will not retaliate against you for filing a complaint. If you wish to obtain additional information about any of the matters discussed in this notice you may contact I Ola Lāhui at 525-6255.

This Notice is effective as of April 14, 2003.