Optima Health Insurance Company
4417 Corporation Lane
Virginia Beach, VA 23462

External Portal User Profile

for access to www.optimahealth.com

Agency Information

Are you appointed with Optima Health? ☐ **Yes** ☐ **No** Date: _____

Agency name

General Agency Name

Physical Address | City | State | Zip

Primary Phone Number | Fax Number

Personal Information

Last Name | First Name | Middle Initial

Social Security Number | Date of Birth | Gender

Tax ID Number *(if applicable)* | NPN Number

Email address

Primary Phone Number | Cell Phone Number

NOTE: All information, except as noted, is required. Incomplete forms will not be processed.

Optima Staff Use Only	
□ Completed	□ Notified

SENTARA®

Statement of Responsibility & Confidentiality

All employees of Sentara Healthcare and any individuals who have access to Sentara Healthcare information, files, data or computer applications must sign and follow this statement of responsibility and confidentiality.

1. I understand and agree that any information I learn during my employment and/or affiliation with Sentara Healthcare regarding patients/families, physicians/dentists/limited health practitioners, and other employees is confidential. I agree not to discuss such information unless my job requires it. Further, I will not give information to anyone who does not have authorized access to it, nor will I attempt to learn information not required by my job.

2. I understand this statement also covers all passwords issued to or used by me to operate Sentara Healthcare computer systems. Therefore, I agree not to tell my passwords to anyone for any reason, not to permit another person to use them, not to use another person's, and not to sign on to any system to allow an unauthorized person to use the system. Further, since my passwords are the equivalent of my legal signature, I agree immediately to change or have changed passwords that have become known to other people.

3. I understand and agree to follow all security policies of specific computer systems to which I am given access. I also understand if I have not used my access to a certain system within 45 days, my access to it may be suspended, and if I have not used it in 60 days, my access may be deleted.

4. I understand and agree that I am responsible for Sentara Healthcare resources, material, and data in my possession. I will take precautions to protect them from theft, temperature changes, water damage, and other intentional damage; I understand that if I do not take reasonable precautions, I may be held liable for any damage incurred.

5. I agree to use Sentara Healthcare hardware, software, and data for business use only and not for personal use, nor will I allow another person to use them for personal use while they are in my possession. I acknowledge that I represent the company when using these resources, material, and data and will not participate in any activities that represent Sentara Healthcare in an unfavorable way.

6. I agree not to make unauthorized copies of copyrighted material, and I understand that I will be held personally liable for any unauthorized copies of copyrighted material made by me.

7. I understand all patient medical information is confidential and agree to treat it as such. I further agree that I will use and disclose such information only in accordance with state and federal laws, including, but not limited to, the regulations promulgated under the Health Insurance Portability and Accountability Act of 1996.

I have read the above and acknowledge that it is my responsibility to adhere to this Statement of Responsibility & Confidentiality at all times. I agree that any violation of this understanding and agreement will result in my losing access to computer systems and is grounds for disciplinary action that may result in dismissal. Sentara Healthcare will retain the original signed copy of this Statement of Responsibility and Confidentiality. I understand that this document does not alter my relationship with Sentara as an at-will employee.

User Name_____ Date _____
(Please print your first, middle, and last name)

User Signature _____
(*By typing your name in the signature field with a back slash before and after your name, you agree and acknowledge that the same constitutes your signature to this agreement which shall become binding upon execution.)

I understand that if the user named above changes job function, transfers to another department, requires leave of absence, or terminates employment, affiliation, or association, I must notify Security Administration immediately.

Supervisor's Name (print)_____ Phone/Location _____
Supervisor's Signature_____ Date _____
(*By typing your name in the signature field with a back slash before and after your name, you agree and acknowledge that the same constitutes your signature to this agreement which shall become binding upon execution.)