BAPTIST PHYSICIAN NETWORK
PATIENT REGISTRATION

Patient Name _____
Last First Initial
Address _____ City_____ State_____ Zip_____

Home Phone # _____ Cell Phone# _____ Social Security _____-_____-_____

Birth Date____-____-____ Age _____Gender_____ Preferred Language_____ Marital Status ___S___M___D___W

Race_____ Ethnicity_____ Email Address_____

Occupation_____Employer_____Work #_____

Pharmacy: _____

PRIMARY INSURANCE

Insured Name_____ Birth Date_____-_____-_____
Last First Initial

Relation to Insured:___Self___Spouse___Other Primary Care Physician _____

Insurance _____ Policy/ID#_____ Group #_____

Billing Address_____ City_____ State _____ Zip_____

Insurance Phone #_____ Employer _____ Work #_____

SECONDARY INSURANCE

Insured Name_____ Birth Date_____-_____-_____
Last First Initial

Relation to Insured:___Self___Spouse___Other Primary Care Physician _____

Insurance _____ Policy/ID#_____ Group #_____

Billing Address_____ City_____ State _____ Zip_____

Insurance Phone #_____ Employer _____ Work #_____

RESPONSIBLE PARTY

Name _____ Social Security # _____

Address _____City_____ State_____ Zip_____

Relation to Patient _____Self ____Spouse_____Other Phone #_____

EMERGENCY CONTACT

Name_____ Relationship_____ Phone #_____

I hereby authorize payment of Medicare, ALL other insurance benefits to be made directly to Baptist Physician Network for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. I hereby authorize to release all information necessary to secure the payment of benefits.

X_____ Date_____
Signature of Patient (or parent if Minor) 01/16

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Patient History Form

Date of first appointment: ____ / ____ / ____ (Month / Day / Year) Birthplace: _____

Name: _____ (last / first / middle initial / maiden) Birthdate: ____ / ____ / ____ (Month / Day / Year)

Address: _____ (Street / apt#) Age _____ Sex: F ❑ M ❑

_____ (City / State / Zip) Telephone: Home: (____) _____
Work: (____) _____

MARITAL STATUS: ❑ Never Married ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

Spouse/Significant Other: ❑ Alive/Age _____ ❑ Deceased/Age _____ Major Illnesses: _____

EDUCATION *(circle highest level attended):*

Grade School 7 8 9 10 11 12 College 1 2 3 4 Graduate School _____

Occupation _____ Number of hours worked/Average per work: _____

Referred here by: *(check one)* ❑ Self ❑ Family ❑ Friend ❑ Doctor ❑ Other Health Professional

Name of person making referral: _____

The name of the physician providing your primary medical care: _____

Describe briefly your present symptoms: _____

_____

_____

_____

_____

Date symptoms began *(approximate)*: _____

Diagnosis: _____

Previous treatment for this problem *(include physical therapy, surgery and injections; medications to be listed later)*:

_____

_____

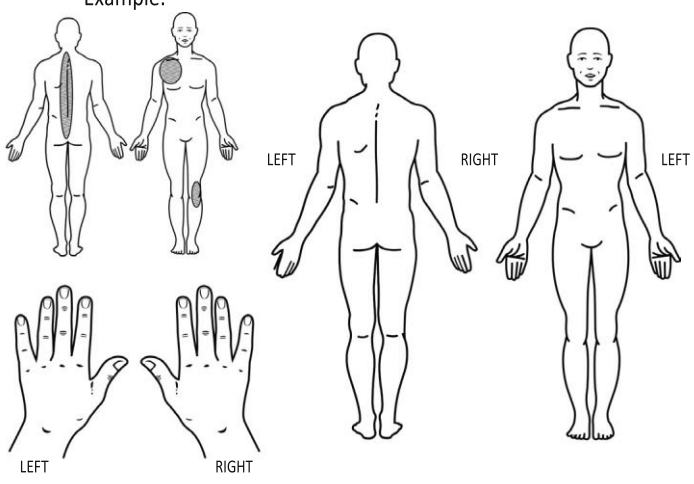
_____

Please list the names of other practitioners you have seen for this problem:

_____

_____

Please shade all the locations of your pain **over the past week** on the **body figures** and **hands**.



Adapted from CLINHAQ, Wolfe F and Pincus T. Current Comment – Listening to the patient – A practical guide to self report questionnaires in clinical care. Arthritis Rheum. 1999;42 (9): 1797-808. Used by permission.

RHEUMATOLOGIC (ARTHRITIS) HISTORY

At any time have you or a blood relative had any of the following? *(Check if "yes")*

Yourself		Relative Name/Relationship	Yourself		Relative Name/Relationship
	Arthritis (unknown type)			Lupus or "SLE"	
	Osteoarthritis			Rheumatoid Arthritis	
	Gout			Ankylosing Spondylitis	
	Childhood Arthritis			Osteoporosis	
	Scleroderma			Psoriasis/ Psoriatic Arthritis	
	Vasculitis			Polymyositis/ Dermatomyositis	
	Fibromyalgia			Sjogren's Syndrome	
				Raynauds	

Other arthritis conditions: _____

SOCIAL HISTORY

Do you drink caffeinated beverages?

Cups/glasses per day? _____

Do you smoke? ❑ Yes ❑ No ❑ Past – How long ago? _____

Do you drink alcohol? ❑ Yes ❑ No Number per week _____

Has anyone ever told you to cut down on your drinking?

❑ Yes ❑ No

Do you use drugs for reasons that are not medical? ❑ Yes ❑ No

If yes, please list: _____

_____

Do you exercise regularly? ❑ Yes ❑ No

Type _____

Amount per week _____

How many hours of sleep do you get at night? _____

Do you get enough sleep at night? ❑ Yes ❑ No

Do you wake up feeling rested? ❑ Yes ❑ No

Are you receiving disability? ❑ Yes ❑ No

Are you applying for disability? ❑ Yes ❑ No

PAST MEDICAL HISTORY

Do you now have or have you ever had: *(check if "yes)*

❑ Cancer
❑ Thyroid
❑ Cataracts
❑ Depression
❑ Bad headaches
❑ Kidney disease/ Stones
❑ Anemia
❑ Emphysema
❑ Heart problems
❑ Leukemia
❑ Diabetes
❑ Stomach ulcers
❑ Hepatitis/ Liver Disease
❑ Pneumonia
❑ High Cholesterol
❑ Blood Clots
❑ Asthma
❑ Stroke
❑ Epilepsy
❑ Rheumatic fever
❑ Crohn's/ Ulcerative Colitis
❑ Psoriasis
❑HighBlood Pressure
❑ Tuberculosis

Other significant illness *(please list)* _____

_____

Natural or Alternative Therapies (chiropractic, magnets, massage, over-the-counter preparations, etc.)

_____

_____

_____

SYSTEMS REVIEW

As you review the following list, please check any problems, which have significantly affected you:

Date of last mammogram: ___/___/___ Date of last eye exam: ___/___/___ Date of last chest x-ray: ___/___/___

Date of last Tuberculosis Test ___/___/___ Date of last bone densitometry ___/___/___

Constitutional

- ❑ Recent weight gain amount _____
- ❑ Recent weight loss amount _____
- ❑ Fatigue
- ❑ Weakness
- ❑ Fever

Eyes

- ❑ Pain
- ❑ Redness
- ❑ Loss of vision
- ❑ Double or blurred vision
- ❑ Dryness
- ❑ Feels like something in eye
- ❑ Itching eyes

Ears-Nose-Mouth-Throat

- ❑ Ringing in ears
- ❑ Loss of hearing
- ❑ Nosebleeds
- ❑ Loss of smell
- ❑ Dryness in nose
- ❑ Runny nose
- ❑ Sore tongue
- ❑ Bleeding gums
- ❑ Sores in mouth
- ❑ Loss of taste
- ❑ Dryness of mouth
- ❑ Frequent sore throats
- ❑ Hoarseness
- ❑ Difficulty swallowing

Cardiovascular

- ❑ Chest Pain
- ❑ Irregular heart beat
- ❑ Sudden changes in heart beat
- ❑ High blood pressure
- ❑ Heart murmurs

Respiratory

- ❑ Shortness of breath
- ❑ Difficulty breathing at night
- ❑ Swollen legs or feet
- ❑ Cough
- ❑ Coughing of blood
- ❑ Wheezing (asthma)

Gastrointestinal

- ❑ Nausea
- ❑ Vomiting of blood or coffee ground material
- ❑ Stomach pain relieved by food or milk
- ❑ Jaundice
- ❑ Increasing constipation
- ❑ Persistent diarrhea
- ❑ Blood in stools
- ❑ Black stools
- ❑ Heartburn

Genitourinary

- ❑ Difficult urination
- ❑ Pain or burning on urination
- ❑ Blood in urine
- ❑ Cloudy, “smoky” urine
- ❑ Pus in urine
- ❑ Discharge from penis/vagina
- ❑ Getting up at night to pass urine
- ❑ Vaginal dryness
- ❑ Rash/ulcers
- ❑ Sexual difficulties
- ❑ Prostate trouble

For Women Only:

Age when periods began: _____

Periods regular? ❑ Yes ❑ q No

How many days apart? _____

Date of last period? ___/___/___

Date of last pap? ___/___/___

Bleeding after menopause? ❑ Yes ❑ No

Number of pregnancies? _____

Number of miscarriages? _____

Musculoskeletal

- ❑ Morning stiffness

Lasting how long?

_____Minutes _____Hours

- ❑ Joint pain
- ❑ Muscle weakness
- ❑ Muscle tenderness
- ❑ Joint swelling

List joints affected in the last 6 mos.

_____

_____

_____

_____

Integumentary (skin and/or breast)

- ❑ Easy bruising
- ❑ Redness
- ❑ Rash
- ❑ Hives
- ❑ Sun sensitive (sun allergy)
- ❑ Tightness
- ❑ Nodules/bumps
- ❑ Hair loss
- ❑ Color changes of hands or feet in The cold

Neurological System

- ❑ Headaches
- ❑ Dizziness
- ❑ Fainting
- ❑ Muscle spasm
- ❑ Loss of consciousness
- ❑ Sensitivity or pain of hands and/or feet
- ❑ Memory loss
- ❑ Night sweats

Psychiatric

- ❑ Excessive worries
- ❑ Anxiety
- ❑ Easily losing temper
- ❑ Depression
- ❑ Agitation
- ❑ Difficulty falling asleep
- ❑ Difficulty staying asleep

Endocrine

- ❑ Excessive thirst

Hematologic/Lymphatic

- ❑ Swollen glands
- ❑ Tender glands
- ❑ Anemia
- ❑ Bleeding tendency
- ❑ Transfusion/when _____

Allergic/Immunologic

- ❑ Frequent sneezing
- ❑ Increased susceptibility to infection

PREVIOUS SURGERIES

Type	Year	Reason
1.		
2.		
3.		
4.		
5.		
6.		
7.		

Any previous fractures? ❑ No ❑ Yes *Describe:*_____

Any other serious injuries? ❑ No ❑ Yes *Describe:*_____

FAMILY HISTORY

	IF LIVING		IF DECEASED	
	Age	**Health**	**Age at Death**	**Cause**
Father				
Mother				

Number of siblings_____ Number living_____ Number decreased_____

Number of children_____ Number living_____ Number decreased_____ List ages of each_____

Health of children_____

MEDICATIONS

Drug allergies: ❑ No ❑ Yes If yes, please list**:**_____

Type of reaction:_____

PRESENT MEDICATIONS *(List any medications you are taking. Include such items as aspirin, vitamins, laxatives, calcium and other supplements, etc.)*

Name of Drug	Dose (include strength & number of pills per day)	How long have you taken this medication	*Helped?* A Lot	Some	Not At All
1.			❑	❑	❑
2.			❑	❑	❑
3.			❑	❑	❑
4.			❑	❑	❑
5.			❑	❑	❑
6.			❑	❑	❑
7.			❑	❑	❑
8.			❑	❑	❑
9.			❑	❑	❑
10.			❑	❑	❑

PAST MEDICATIONS: Please review this list of "arthritis" medications. As accurately as possible, try to remember which medications you have taken, how long you were taking the medication, the results of taking the medication and list any reactions you may have had. *Record your comments in the spaces provided.*

Drug names/Dose	Length of time	Please check: *Helped?* A Lot	Some	Not At All	Reactions
Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)		❑	❑	❑	
Circle any you have taken in the past Arthrotec/ Diclofenac + misoprostil Celebrex/ Celecoxib Sulindac/ Clinoril Oxaprozin/ Daypro Diflunisal/ Dolobid Piroxicam/ Feldene Indomethacin /Indocin Etodolac /Lodine Ibuprofen/ Mortin/ Advil Relafen/ Nabumetone Naproxen/ Aleve/ Naprosyn Ketoprofen/ Orvdis Tolmetin/ Tolectin Meloxicam/ Mobic Diclofenac/ Voltaren					
Pain Relievers					
Acetaminophen		❑	❑	❑	
Codeine		❑	❑	❑	
Hydrocodone/ Vicodin/ Norco		❑	❑	❑	
Ultram/ Tramadol		❑	❑	❑	
Other:		❑	❑	❑	
Disease Modifying Antirheumatic Drugs (DMArDS)					
Certolizumab/ Cimzia		❑	❑	❑	
Golimumab/ Simponi		❑	❑	❑	
Hydroxychloroquine/ Plaquenil		❑	❑	❑	
Leflunomide/ Arava		❑	❑	❑	
Methotrexate		❑	❑	❑	
Azathioprine/ Imuran		❑	❑	❑	
Sulfasalazine/ Azulfidine		❑	❑	❑	
Abatacept/ Orencia		❑	❑	❑	
Cyclophosphamide/ Cytoxan		❑	❑	❑	
Cyclosporine A/ Neoral		❑	❑	❑	
Etanercept/ Enbrel		❑	❑	❑	
Infliximab/ Remicade		❑	❑	❑	
Tocilizumab/ Actemra		❑	❑	❑	
Sarilumab/ Kevzara		❑	❑	❑	
Adalimumab/ Humira		❑	❑	❑	
Mycophenolate Mofetil/ Cellcept		❑	❑	❑	
Belimumab/ Benlysta		❑	❑	❑	
Rituximab/ Rituxan		❑	❑	❑	
Secukinumab/ Cosentyx		❑	❑	❑	
Ixekizumab/ Taltz		❑	❑	❑	
Vedolizumab/ Entyvio		❑	❑	❑	
Ustekinumab/ Stelara		❑	❑	❑	
Tofacitinib/ Zeljanz		❑	❑	❑	
Baricitinib/ Olumiant		❑	❑	❑	
Apremilast/ Otezla		❑	❑	❑	
Other:		❑	❑	❑	

PAST MEDICATIONS *Continued*

Drug names/Dose	Length of time	Please check: *Helped?* A Lot	Some	Not At All	Reactions
Osteoporosis Medications					
Estrogen		❑	❑	❑	
Alendronate/ Fosamax		❑	❑	❑	
Ibandronate/ Boniva		❑	❑	❑	
Raloxifene/ Evista		❑	❑	❑	
Zoledronic acid/ Reclast		❑	❑	❑	
Denosumab/ Prolia		❑	❑	❑	
Risedronate/ Actonel/ Atelvia		❑	❑	❑	
Teriparatide/ Forteo		❑	❑	❑	
Other:		❑	❑	❑	
Gout Medications					
Probenecid/ Benemid		❑	❑	❑	
Colchicine/ Colcyrs		❑	❑	❑	
Allopurinol/ Zyloprim		❑	❑	❑	
Febuxostat/ Uloric		❑	❑	❑	
Pegloticase/ Kyrstexxa		❑	❑	❑	
Lesinurad/ Zurampic		❑	❑	❑	
Others					
Cortisone/ Prednisone		❑	❑	❑	
Viscosupplement Injections/ Supartz/ Synvisc/ Hyalgan/ Euflexxa		❑	❑	❑	
Fibromyalgia Medications					
Duloxetine/ Cymbalta		❑	❑	❑	
Pregabalin/ Lyrica		❑	❑	❑	
Milnacipran/ Savella		❑	❑	❑	
Cyclobenzaprine/ Flexeril		❑	❑	❑	
Amitriptyline/ Elavil		❑	❑	❑	
Fluoxetine/ Prozac		❑	❑	❑	

Please list supplements: _____

_____

Have you had a pneumonia shot? ❑ Yes ❑ No If so, list date _____

Have you had a flu shot? ❑ Yes ❑ No If so, list date _____

Have you had a shingles shot? ❑ Yes ❑ No If so, list date _____

Patient's Name: _____Date:_____Physician Initial: _____

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REQUEST FOR LIMITATIONS AND RESTRICTIONS OF PROTECTED HEALTH INFORMATION (PHI)

PATIENT PLEASE NOTE: THE PRACTICE IS NOT REQUIRED TO AGREE TO YOUR REQUEST. PLEASE SEE OUR NOTICE OF PRIVACY PRACTICES FOR MORE INFORMATION REGARDING SUCH REQUESTS.

Patient Name: _____ Date of Birth: _____

Patient Address: _____
Street

_____
Apartment #

_____
City, State and Zip Code

Type of PHI to be restricted or limited: (Please check all that apply. Note: should you need to be referred to another physician, anything checked will ***NOT*** be shared.)

_____ Home phone #
_____ Home address
_____ Occupation
_____ Name of employer
_____ Visit notes
_____ Hospital notes
_____ Prescription information
_____ Patient History
_____ Office address
_____ Office phone #
_____ Spouse's name
_____ Spouse's office phone #
_____ Other: _____

How may we use and/or disclose of your PHI restricted information?

_____

_____

_____

_____ _____
Signature of Patient or Legal Guardian Date

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PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing this authorization, I authorize, Baptist Physician Network, to use and/or disclose certain Protected Health Information (PHI) about me to the following family members:

_____

_____

_____

This authorization permits Baptist Physician Network to use and/or disclose medical and/or billing information directly related to my diagnosis and/or treatment. This information will be used or disclosed at the request of myself or the person(s) designated above. This authorization will not expire unless specifically revoked by either myself or the person(s) designated above.

I do not have to sign this authorization in order to receive treatment from Baptist Physician. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPPA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at:

Signed by:

_____ _____
Signature of Patient or Legal Guardian Relationship to Patient

_____ _____
Print Name of Patient or Legal Guardian Date

PATIENT/GUARDIAN TO BE PROVIDED WITH A SIGNED COPY OF AUTHORIZATION

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RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

I, _____, have received a copy of Baptist Physician Network
Patient's Name

Notice of Privacy Practices.

_____ _____
Signature of Patient Date

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient's Name: _____

Last First Middle Initial

Date of Birth: _____-_____-_____ Social Security Number:_____-_____-_____

I request a copy of medical records from _____ (date) to_____ (date)

On the above named patient for the following reason(s):

_____Change in Primary Care Provider

_____Moving or Relocating to another area

_____Other: (please explain) _____

_____

From:_____

Name of Releasing Physician or Facility

Phone:_____ **Fax:**_____

To:_____

Physician, Facility, or Person receiving Records

Phone:_____ **Fax:**_____

_____ _____

Signature of Patient or Authorized Representative Date

I hereby authorize the release of all medical records except notes forwarded by a mental health professional, such as a Psychiatrist, Psychologist, or a Licensed Professional Counselor. I hereby release BAPTIST PHYSICIAN NETWORK from liability associated with this release.

Please complete all fields on this form. Omitted information may cause a delay in your request. 01/16

740 Hospital Dr., Suite 150 * Beaumont, TX. 77701 * Phone (409)212-5115 * Fax (409)212-5112

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New Patient Appointment Cancellation/No Show Policy

Thank you for trusting your medical care to Baptist Physician Network. When you schedule an appointment, with Baptist Physician Network, our desire is to provide you with the highest quality care. This includes making sure that you are provided with an appropriate time and appointment type. Please see our New Patient Appointment Cancellation/No Show Policy below:

- The office will call you to confirm your new patient appointment, one week prior to the appointment. You will also receive an automated call reminder, the week of, or a few days prior to your appointment.
- Any New Patient who fails to show for their initial visit will not be rescheduled.
- Should you need to cancel or reschedule an appointment please contact our office as soon as possible and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients, who may be waiting for an appointment.

We understand there may be times when an unforeseen emergency occurs and you may not be able to keep your scheduled appointment. If you should experience these circumstances please contact our office, as soon as you are able, to discuss options that may be available. You may contact our office during our normal business hours with such appointment requests and/or changes. Thank you for understanding and allowing us to care for your medical needs.

I have read and understand the Medical Appointment Cancellation/No Show Policy and agree to its terms.

_____ _____

Signature (Parent/Legal Guardian) **Relationship to Patient**

_____ _____

Printed Name **Date**

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CONSENT/AUTHORIZATION for TREATMENT

1) I consent to services, treatment and diagnostic procedures, including but not limited to medications and lab test which may be ordered by my provider at BAPTIST Physician Network.

2) I acknowledge full responsibility for the payment of such services and agree to pay my bills in full AT TIME OF SERVICE unless other arrangements are made. By signing this consent I assign all rights, title and interest and authorize direct payment to the BAPTIST Physician Network of any insurance benefits or benefits under the Social Security Act for the services. BAPTIST Physician Network will assist in billing my insurance company but I am financially responsible for charges not collected by this assignment. I authorize BAPTIST Physician Network to bill my insurance or third party payor and receive payment from them directly.

3) I acknowledge that to the extent necessary to determine liability for payment or to obtain reimbursement, BAPTIST Physician Network may disclose my records to any person, Social Security Administration, insurance or benefit payor, health care service or plan, worker's compensation carrier is, or may be, liable for all or any of the charges. Furthermore BAPTIST Physician Network may disclose my records to other treating providers, health care providers, audit committees for the purpose of quality improvement, and applicable state and federal agencies.

4) My signature acknowledges that I have been given the right to ask questions and receive information about any services and I voluntarily sign this consent. This authorization shall remain valid for a period of one year unless I revoke it in writing. A photocopy or a faxed copy of this authorization shall be deemed as valid as the original.

Signed: _____ Date: _____
(Patient, Parent or Guardian)

Relationship to Patient: _____ Date: _____

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Dear valued patient:

The most valuable information that I need to properly take care of you is an accurate medication list. Therefore, I strongly urge you to bring all your MEDICATION BOTTLES with you each time you come for an office visit so we can compare it to our current list and make sure it is accurate. I must have a correct list of your medications, dosage, and the frequency in which you are taking these medications to care for you properly. I also need to be aware of any over-the-counter medications you are taking. As many patients see multiple physicians it is often possible you may be taking medications or had dosage changes that I am not aware of. In addition I request that you call us immediately with any change in your medications or medication dosages. Failure to comply with the above request could lead to serious errors in your treatment with the potential for significant morbidity and mortality. By signing below you attest that you have read and understand the potential seriousness of your noncompliance with this request.

Signature:_____ Date:_____

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.

This notice takes effect on _____January 1, 2017_____ and remains in effect until we replace it.

1. OUR PLEDGE REGARDING MEDICAL INFORMATION

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

2. Our Legal Duty

Law Requires Us to:

1. Keep your medical information private.
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
3. Follow the terms of the notice that is now in effect.

We Have the Right to:

1. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

Notice of Change to Privacy Practices:

1. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

3. USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us.

FOR TREATMENT: We may use medical information about you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people who are taking care of you. We may also share medical information about you to your other health care providers to assist them in treating you.

FOR PAYMENT: We may use and disclose your medical information for payment purposes.

FOR HEALTH CARE OPERATIONS: We may use and disclose your medical information for our health care operations. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs, and getting the accreditation, certificates, licenses and credentials we need to serve you.

NOTICE OF PRIVACY PRACTICES

ADDITIONAL USES AND DISCLOSURES: In addition to using and disclosing your medical information for treatment, payment, and health care operation, we may use and disclose medical information for the following purposes.

Facility Directory: Unless you notify us that you object, the following medical information about you will be placed in our facilities' directories: your name; your location in our facility; your condition described in general terms; your religious affiliation, to others who contact us and ask for information about you by name.

Notification: Medical information to notify or help notify: a family member, your personal representative or another person responsible for your care. We will share information about your location, general condition, or death. If you are present, we will get your permission if possible before we share, or give you the opportunity to refuse permission. In case of emergency, and if you are not able to give or refuse permission, we will share only the health information that is directly necessary for your health care, according to our professional judgment. We will also use our professional judgment to make decisions in your best interest about allowing someone to pick up medicine, medical supplies, x-ray or medical information for you.

Disaster Relief: Medical information with a public or private organization or person who can legally assist in disaster relief efforts.

Fundraising: We may provide medical information to one of our affiliated fundraising foundations to contact you for fundraising purposes. We will limit our use and sharing to information that describes you in general, not personal, terms and the dates of your health care. In any fundraising materials, we will provide you a description of how you may choose not to receive future fundraising communications.

Research in Limited Circumstances: Medical information for research purposes in limited circumstances where the research has been approved by a review board that has reviewed the research proposal and established to protocols to ensure the privacy of medical information.

Funeral Director, Coroner, Medical Examiner: To help them carry out their duties, we may share the medical information of a person who has died with a coroner, medical examiner, funeral director, or an organ procurement organization.

Specialized Government Functions: Subject to certain requirements, we may disclose or use health information for military personnel and veterans, for national security and intelligence activities, for protective services for the President and others, for medical suitability determinations for the Department of State, for correctional institutions and other law enforcement custodial situations, and for government programs providing public benefits.

Court Orders and Judicial and Administrative Proceedings: We may disclose medical information in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such as court order, warrant, or grand jury subpoena, we may share your medical information with law enforcement officials. We may share limited information with a law enforcement official concerning the medical information of a suspect, fugitive, material witness, crime victim or missing person. We may share medical information of an inmate or other person in lawful custody with a law enforcement official or correctional institution under certain circumstances.

Public Health Activities: As required by law, we may disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse or neglect. We may also disclose your medical information to persons subject to jurisdiction of the Food and Drug Administration for purposes of reporting adverse events associated with product defects or problems, to enable product recalls, repairs or replacements, to track products, or to conduct activities required by the Food and Drug Administration. We may also,

when we are authorized by law to do so, notify a person who may have been exposed to a communicable disease or otherwise be at risk of contracting or spreading a disease or condition.

NOTICE OF PRIVACY PRACTICES

Victims of Abuse, Neglect, or Domestic Violence: We may disclose medical information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may share your medical information if it is necessary; to prevent a serious threat to your health or safety or the health or safety of others. We may share medical information when necessary to help law enforcement officials capture a person who has admitted to being part of a crime or has escaped from legal custody.

Workers Compensation: We may disclose health information when authorized and necessary to comply with laws relating to workers compensation or other similar programs.

Health Oversight Activities: We may disclose medical information to an agency providing health oversight for oversight activities authorized by law, including audits, civil, administrative, or criminal investigations or proceedings, inspections, licensure or disciplinary actions, or other authorized activities.

Law Enforcement: Under certain circumstances, we may disclose health information to law enforcement officials. These circumstances include reporting required by certain laws (such as the reporting of certain types of wounds), pursuant to certain subpoenas or court orders, reporting limited information concerning identification and location at the request of a law enforcement official, reporting death, crimes on our premises, and crimes in emergencies.

4. YOUR INDIVIDUAL RIGHTS

You Have a Right to:

1. Look at or get copies of your medical information. You may request that we provide copies in a format other than photocopies. We will use the format you request unless it is not practical for us to do so. You must make your request in writing. You may get the form to request access by using the contact information listed at the end of this notice. You may also request access by sending a letter to the contact person listed at the end of this notice. If you request copies, we will charge you $_____ for each page, and postage if you want the copies mailed to you. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.
2. Receive a list of all the time we or our business associates shared your medical information for purposes other than treatment, payment, and health care operations and other specified exceptions.
3. Request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of an emergency).
4. Request that we communicate with you about your medical information by different means or to different locations. Your request that we communicate your medical information to you by different means or at different locations must be made in writing to the contact person listed at the end of this notice.
5. Request that we change your medical information. We may deny your request if we did not create the information you want changed or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement that will be added to the information you wanted changed. If we accept your request to change the information, we will make reasonable efforts to tell others, including people you name, of the change and to include the changes in any future sharing of that information.
6. If you have received this notice electronically, and wish to receive a paper copy, you have the right to obtain a paper copy by making a request in writing to the Privacy Officer at your office.

QUESTIONS AND COMPLAINTS

If you have any questions about this notice or if you think that we may have violated your privacy rights, please contact us. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services. We will not retaliate in any way if you choose to file a complaint.