Brookwood Baptist Health

Specialty Care Network
Sports Medicine

Date: _____

Email: _____

Patient Registration Form

PATIENT INFORMATION				
Name (Last, First, Middle)	Preferred Name	Social Security Number	Sex (M/F)	Date of Birth
Home Address		City/ State	Zip Code	Driver's License #
Email Address		Home Phone #	Cell Phone#	
Employer Name		Work Phone #	Marital Status Single Married Widowed Divorced	
Emergency Contact (Not living with you)		Relationship	Emergency Phone	
School			Sport	
Reason for Visit			Date of Accident/Injury	
How did accident/injury occur?				
Please list all drug allergies.				

Ethnicity	☐ Hispanic	☐ Other	☐ Not Reported			
Race	☐ Caucasian	☐ African American	☐ Hispanic	☐ Asian	☐ American Indian	☐ Other
Primary Language	☐ English	☐ Spanish	☐ French	☐ Japanese	☐ Chinese	☐ Other
Gender	☐ Male	☐ Female				

RESPONSIBLE PARTY INFORMATION (IF DIFFERENT THAN ABOVE)				
Name (Last, First, Middle)	Social Security Number	Date of Birth	Age	Sex
Local Address	City, State, Zip	Secondary Billing Address (if applicable)		
Home Phone #	Cell Phone #	Relationship to Patient		

PRIMARY INSURANCE		
Name of Insurance Company	Address (Street, City, St, Zip)	CoPay
Policy Holder Name	Social Security Number of Policy Holder	DOB
Contract #	Group #	Effective Date

SECONDARY INSURANCE (IF APPLICABLE)		
Name of Insurance Company	Address (Street, City, St, Zip)	CoPay
Policy Holder Name	Social Security Number of Policy Holder	DOB
Contract #	Group #	Effective Date

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WORKER'S COMPENSATION		
Is this a Workman Compensation Case? (If yes, please provide the following information) ☐ Yes ☐ No	Employer	Date of Injury
Work Comp Carrier	Address	
LIST ANY COACH, TRAINER, OR DOCTOR, AS WELL AS THE COMPLETE ADDRESS THAT YOU WANT TO RECEIVE A REPORT.		
Doctor	Coach/Trainer	
Pharmacy Name, Address, and Phone Number		

HOW DID YOU HEAR ABOUT US? (CHECK ALL THAT APPLY)					
☐ Billboard	☐ Event	☐ Tenet Employee	☐ Rating Website	☐ Word of Mouth	☐ Tenet Employee
☐ Sign	☐ Zoc Doc	☐ Social Media	☐ Internet Search	☐ Insurance	☐ Doctor Referral _____
☐ Radio	☐ Postcard/flyer	☐ Urgent Care/ER	☐ Magazine/Newspaper Ad	☐ Television	☐ Other _____

I consent to treatment necessary for the care of the above named patient. I acknowledge full financial responsibility for services rendered by Brookwood Baptist Health, Primary Care Network. I agree to pay all reasonable attorney fees and collection costs in the event of default of payment. I have read and fully understand the above consent for treatment and financial responsibility.

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

Financial Policy and Authorizations

We are happy that you selected Brookwood Baptist Health, Primary Care Network for your healthcare needs and look forward to working with you. To help you understand your financial responsibilities in relation to your medical care, we would like to briefly outline our financial policies.

Patients are expected to provide identification and if insured, a current insurance card(s) at time of service. Patients are financially responsible for all services provided and are expected to pay for services at time of service, including any past due balance from a prior date of service. If the patient is a minor child, the parent or other adult accompanying the child will be financially responsible regardless of legal guardianship. Returned checks will be subject to fees.

Medicare: The office will bill the Medicare intermediary. Patients are responsible for the following:

- Annual Medicare deductible
- All applicable co-pays of the allowed charge
- Any non-covered services
- Any covered service ordered by the physician which does not meet Medicare's medical necessity and for which the beneficiary signed an Advanced Beneficiary Notice (ABN).

Medicare Supplemental and Secondary Insurances: The Practice will bill both Medicare and secondary insurances.

Medicaid: Patients must provide the Practice with a current Medicaid card at each visit. Medicaid patients are responsible for applicable co-pays and for all non-covered services. Medicaid patients are responsible for securing necessary referrals from their primary care physicians.

HMOs and PPOs, Commercial Insurance Plans: Patients are responsible for payment of the co-pay, co-insurance and/or deductible, or non-covered amounts at the time of service as well as for any charges for which the patient failed to secure prior authorization, if authorization is necessary. Insurance is filed as a courtesy and benefits are authorized to be paid directly to the Practice. Patients are responsible for the balance in full if not paid by the insurance within 30 days. If the patient is not prepared to pay the co-pay or deductible, a member of the clinical staff will determine if it is medically necessary for the patient to see the physician. If the patient's condition allows, the appointment will be rescheduled.

Self-Pay: Patients are responsible for payment in full at the time of services for all services rendered.

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Worker's Compensation: Employer authorization must be obtained before treatment is rendered or the patient will be responsible for payment in full at the time of services for all services rendered. Once authorized, patients are not responsible for any charges unless the workers compensation case is dismissed or denied.

Personal Injury/Motor Vehicle Accidents and Other Third Party Liability: The patient is responsible for the balance in full at the time of service. Any settlement you receive from your insurance company or other third party will be handled by you, your insurance company, and/or your attorney.

Out of State Insurance: If the patient presents with an out of state HMO/PPO insurance card, we will need to verify the patient's benefits for out-of-state or out-of-network benefits. The patient may be required to make payment in full or pay any co-pay, co-insurance or deductible.

Authorizations and Consent

ASSIGNMENT AND RELEASE: I hereby assign my insurance or other third party carrier benefits to be paid directly to the Physician Practice, realizing I am responsible for any resulting balance. I also authorize the Physician to release any information required to process this claim to my insurance carrier and/or to my employer or prospective employer (for employer sponsored/paid for claims). I acknowledge that I am financially responsible for services rendered, and failure to pay any outstanding balances may result in collection procedures being taken. Further, I agree that if this account results in a credit balance, the credit amount will be applied to any outstanding accounts of mine, or to a family member whose account I am guarantor for.

ELECTRONIC CHECK CONVERSION: When you provide a check as payment, you authorize us either to use information from your check to make a one-time electronic fund transfer from your account or to process the payment as a check transaction. When we use information from your check to make an electronic fund transfer, funds may be withdrawn from your account the same day.

CONSENT FOR TREATMENT: I hereby authorize the physicians, midlevel providers, nurses, medical assistants, and other Practice staff to conduct such examinations, and to administer treatment and medications as they deem necessary and advisable.

NO SHOW POLICY: I understand if I fail to come for a scheduled appointment or cancel at least 24 hours prior to the appointment, I will be considered a "no show" and may be subject to a "no show" charge per occurrence. Ongoing occurrences of no shows may result in dismissal from the Practice.

I understand the Financial and No Show Policies, Authorizations and Consent for Treatment, and hereby agree to them:

Patient or Parent/Guardian: _____ Date: _____

NOTICE OF PRIVACY PRACTICES (NPP) ACKNOWLEDGEMENT

A Notice of Privacy Practices (NPP) is provided to all patients and explains: (1) how your Protected Health Information (PHI) may be used or shared; (2) your rights to access or amend your PHI, request information on disclosures of your PHI, and request additional restrictions on our uses and disclosures of PHI; (3) your rights to complain if you believe your privacy rights have been violated; and (4) our responsibilities for maintaining the privacy of your PHI.

- I acknowledge that I have received a copy of the "Notice of Privacy Practices" (Version 3 August 2013 dated 09/23/2013) that explains when, where, and why my Protected Health Information (PHI) may be used or shared.
- I authorize Brookwood Baptist Health, Primary Care Network to furnish complete information, including Protected Health Information, requested by my insurance carrier or its intermediaries regarding services rendered. I hereby authorize my insurance carrier to furnish to Brookwood Baptist Health, Primary Care Network any information obtained in the adjudication of any claim for services furnished to me by Brookwood Baptist Health, Primary Care Network.
- I acknowledge that Brookwood Baptist Health, Primary Care Network, the physicians, the nurses, and other staff may obtain and share any or all of my Protected Health Information, including prescription history, with other health care professionals in order to treat me, coordinate my care, and/or in order to arrange for payment of my bill and respond to any issues related to my care.
- I acknowledge that I have the right to request additional restrictions on the use and disclosure of my PHI if I so choose.

Name of Patient/ or Guardian (if Minor): _____

Signature of Patient/or Guardian: _____ Date: _____

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PATIENT COMMUNICATION CONSENT

We may need to contact you regarding your medical care. This is to acknowledge that you authorize Brookwood Baptist Health, Primary Care Network to (check all that apply):

☐ Leave a detailed message on voice mail/machine

☐ Call my workplace phone number and leave a message

☐ Call my workplace phone number and speak only to me

☐ Transmit and Receive messages through Patient Portal (NextMD or Other) including secure email

☐ None of the above

I further authorize the disclosure of my PHI to the following individuals or family members:

Name: _____ Relationship to Patient_____

Name: _____ Relationship to Patient_____

Name: _____ Relationship to Patient_____

Signature of Patient/Guardian: _____ Date: _____

A federal law was passed in 2014 and became effective on September 30, 2014, governing how we may contact you via telephone, text, and email. Listed below are some of the reasons we may need to contact you via telephone, text, or email:

- Appointment reminders
- Follow up with test results
- Reminder calls about annual preventive care due
- Email or fax with patient forms to complete prior to your appointment
- Notification of medication renewals
- Notification of surgery time and date
- Notification of prepayments for surgeries and procedures
- Follow up calls after surgeries or procedures

Consent to Contact

By providing a telephone number, I expressly consent and authorize the physician practice, any practitioner or clinical provider as well as any of their related entities, agents, or contractors, including but not limited to schedulers, marketers, advertisers, debt collectors, and other contracted staff (collectively referred to herein as "Provider") to contact me through the use of any dialing equipment (including a dialer, automatic telephone dialing system, and/or interactive voice recognition system) and/or artificial or prerecorded voice or message. I expressly agree that such automated calls may be made to any telephone number (including numbers assigned to any cellular or other service for which I may be charged for the call) used by, or associated with me and obtained through any source including, but not limited to, any number I am providing today, have provided previously or may provide in the future in connection with the medical goods and services and/or my account. By providing this express consent, I specifically waive any claim I may have for the making of such calls, including any claim under federal or state law and specifically any claim under the Telephone

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Consumer Protection Act, 47 U.S.C. § 227. By providing a telephone number, I represent I am the subscriber or owner or have the authority to use and provide consent to call the number.

By providing a telephone number, I expressly consent to the receipt of text messages from Provider at any telephone number (including numbers assigned to any cellular or other service for which I may be charged for the call) used by, or associated with, me and obtained through any source including, but not limited to, any number I have provided previously or may provide in the future in connection with my account. By providing this express consent, I specifically waive any claim I may have for the making of such calls, including any claim under federal or state law and specifically any claim under the Telephone Consumer Protection Act, 47 U.S.C. § 227. By providing a telephone number, I represent I am the subscriber or owner or have the authority to use and provide consent to call the number.

By providing my email address now or at any time in the future in connection with the medical goods and services provided and/or my account, I expressly opt-in to the receipt of email communications from Provider for or related to the medical goods or services provided, my account, and other services such as financial, clinical and educational information including exchange news, changes to health care law, health care coverage, care follow up, and other healthcare opportunities, goods and services. By providing this express consent, I specifically waive any claim I may have for the sending of such emails, including any claim under federal or state law and specifically any claim under the CAN-SPAM Act, 15 U.S.C.§ 7701, et seq. By providing an email address, I represent I am the subscriber or owner or have the authority to use and provide consent to contact the email address.

I understand that providing a phone number and/or email address is not a condition of receiving medical services. I also understand that I may revoke my consent to contact at any time by directly contacting Provider or utilizing the opt–out method that will be identified in the applicable communication.

I have read and understand the above and consent to contact as described:

Patient Name: _____ Date of Birth: _____

Signature: _____ Date: _____

***Minors or Users Requiring Caregivers – Acknowledgement of Consent to Contact**

Name: _____ Relationship: _____

Signature: _____ Date: _____

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Authorization for Release of Information

Patient Name (First, MI, Last): _____

Address /City/State/Zip: _____

Phone Number: (_____) _____ **Date of Birth**: _____

This Authorization applies to the following Information:

_____ **ALL Information**. I understand that the following may contain psychiatric/psychological, alcohol/drug abuse, and/or AIDS/HIV information and I expressly consent to the release of the information.

_____ **ONLY** the following records or types of Information_____

Treatment Dates: **from** (Month/Day/Year) _____/_____/_____ **to** (Month/Day/Year) _____/_____/_____

Purpose of the release: Continuity of Care _____ Other (*Specify*_____

I consent for my medical records to go: **TO:** _____ _____ _____	OR	*I consent for my medical records to go:* **FROM:** _____ _____ _____
FROM: _____ _____ _____		**TO:** _____ _____ _____

I understand that my records are protected by federal regulation and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I understand that this authorization is revocable as to future requests upon written receipt of my written revocation. Written revocations are to be sent to the Privacy Officer of the above provider releasing the records. I understand that a revocation is not effective to the extent that the provider has already relied on this authorization for the use of the disclosure of the information. Unless revoked sooner, Authorization shall expire sixty (60) days from the date below.

_____ _____

Authorizing Party Date Witness Date

_____

Authorizing Party (*Other Than Patient*) Date

***IF THE AUTHORIZING PARTY IS NOT THE PATIENT, PLEASE SPECIFY THE RELATIONSHIP TO THE PATIENT AND PROVIDE DOCUMENTATION OR ANY LEGAL AUTHORITY AFT FOR THE PATIENT.**

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Patient History

Patient Name:_____ Sex: □ Male □ Female Date: _____

Date of Birth: _____/_____/_____ Age: _____ Cell Phone #: _____ Can we leave a message? □ Yes □ No

Date of Injury (If applicable): _____

What is the reason for your visit today?

1. _____
2. _____
3. _____

Past Medical History

Please check all that apply:

□ Anemia, Chronic
□ Anxiety
□ Asthma
□ Bipolar Disorder
□ Breast Cancer
□ Chronic Pain
□ COPD
□ Coronary Artery Disease
□ Deep Vein Thrombosis
□ Depression
□ Diabetes, Insulin Dependent
□ Diabetes, Non-Insulin
□ End Stage Renal Disease
□ Fibromyalgia
□ GERD
□ Hepatitis
□ HIV/AIDS
□ High Cholesterol
□ Hyperlipidemia
□ Hyperparathyroidism
□ Hypertension
□ Hyperthyroidism
□ Hypothyroidism
□ Leukemia
□ Lymphoma
□ Multiple Myeloma
□ Obesity, Morbid
□ Obesity
□ PBPH
□ Pulmonary Embolism
□ Radiation Therapy
□ Rheumatoid Arthritis
□ Sleep Apnea
□ Seizures
□ Stroke
□ NONE

□ Cancer (type and location): _____

□ Other: _____

Past Surgical History

Please check and circle all that apply:

□ Appendix (Appendectomy)
□ Breast Mastectomy (Right/Left/Both)
□ Breast Lumpectomy (Right/Left/Both)
□ Colectomy: Colon Cancer Resection
□ Colectomy: Diverticulitis
□ Colectomy: IBD
□ Colon: Colostomy
□ Gallbladder Removal
□ Heart: Biological Valve Replacement
□ Heart: Coronary Artery Bypass Surgery
□ Heart Transplant
□ Heart: Mechanical Valve Replacement
□ Heart: PTCA
□ Hysterectomy
□ Hysterectomy: Caesarean
□ Hysterectomy: Uterine Cancer
□ Hysterectomy: Cervical Cancer
□ Kidney Stone Removal
□ Kidney Transplant
□ Liver: Hepatectomy
□ Liver: Liver Transplant
□ Liver: Shunt
□ Ovaries Removed: Ovarian Cancer
□ Ovaries: Tubal Ligation
□ Pancreas: Pancreatectomy
□ Prostate Removed: Prostate Cancer
□ Prostate Removed: TURP
□ Rectum: APR
□ Rectum: Lower Anterior Resection
□ Skin: Basal Cell Carcinoma
□ Skin: Melanoma
□ Skin: Skin Biopsy
□ Skin: Squamous Cell Carcinoma
□ Heart: Coronary Artery Bypass Surgery
□ NONE

□ Other: _____

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Past Orthopedic History

Please check all that apply:

□ Ankle Fracture
□ Ankylosing Spondylitis
□ Bursitis
□ DISH
□ Epidural Injections, Spine
□ Fracture
□ Gout
□ Hip Fracture
□ HNP, Cervical
□ HNP, Lumbar
□ Metastatic Bone Disease
□ Osteoarthritis
□ Osteoporosis
□ Primary Bone Sarcoma
□ Psoriatic Arthritis
□ Rheumatoid Arthritis
□ Ricketts
□ RSD
□ Sciatica
□ Scoliosis
□ Spine Fracture
□ Soft Tissue Sarcoma
□ Spinal Stenosis, Cervical
□ Spinal Stenosis, Lumbar
□ Vertebral Body Compression Fracture
□ Vitamin D Deficiency
□ Wrist Fracture
□ NONE

□ Other: _____

Past Orthopedic Surgery

Please check and circle all that apply:

□ Achilles Tendon Repair (Right/Left/Both)
□ ACL Reconstruction (Right/Left/Both)
□ Ankle Fracture ORIF (Right/Left/Both)
□ Bunion Correction (Right/Left/Both)
□ Carpal Tunnel Decompression (Right/Left/Both)
□ Cervical Spine Surgery: ACDF
□ Cervical Spine Surgery: Disc Replacement
□ Distal Radius ORIF (Right/Left/Both)
□ Ganglion Cyst Excision
□ Intermedullary Nailing Tibia (Right/Left/Both)
□ Joint Replacement: Hip (Right/Left/Both)
□ Joint Replacement: Knee (Right/Left/Both)
□ Joint Replacement: Shoulder (Right/Left/Both)
□ Knee Arthroscopy (Right/Left/Both)
□ Kyphoplasty/Vertebroplasty
□ Lumbar Fusion
□ Lumbar Laminectomy
□ Lumbar Spine Surgery: Decompression
□ Lumbar Spine Surgery: Decompression and Fusion
□ Lumbar Spine Surgery: Disc Replacement
□ Meniscus Repair (Right/Left/Both)
□ Reverse Total Shoulder Replacement (Right/Left/Both)
□ Revision of Total Knee Arthroplasty (Right/Left/Both)
□ Revision of Total Knee Arthroplasty (Right/Left/Both)
□ Rotator Cuff Repair (Right/Left/Both)
□ Shoulder Arthroscopy (Right/Left/Both)
□ Trigger Finger Release: Location:
□ NONE

□ Other: _____

List all current medications (Dose & Frequency):

1. _____
2. _____
3. _____
4. _____
5. _____

List all current supplements (Dose & Frequency):

1. _____
2. _____
3. _____
4. _____
5. _____

□ I brought a copy of my medication list. (Please provide your allergy list to the front desk receptionist.)
□ Not currently taking any medications.

List any hospitalizations or surgeries you have had (including C-section) and the dates which they occurred. □ None

_____

List any drug allergies (What type of reaction? How severe?) □ No known allergies

1. _____
2. _____
3. _____
4. _____
5. _____

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□ I brought a copy of my allergy list. (Please provide your allergy list to the front desk receptionist.

Preventative Care

What year were these shots or tests given?

Tetanus Booster: _____ Flu Shot: _____ Pneumonia Vaccine: _____ Hepatitis Vaccine: _____

Colonoscopy: _____ Shingles Vaccine (Age >60): _____ Bone Density: _____ PSA: _____

Name:

Social Habits

Have you ever used tobacco products? □ Yes □ No
What kind? _____
How much? _____
For how many years? _____
Date quit _____

Do you drink alcohol? □ Yes □ No
How many drinks per week? _____
Have you ever felt you need to cut down? □ Yes □ No
Have you ever felt guilty about your drinking? □ Yes □ No
Do you use drugs? □ Yes □ No What type?_____

Do you exercise regularly? What form? _____
Briefly describe your diet: _____
Marital Status: □ Married □ Single □ Separated □ Divorced □ Widowed

Family History

Has anyone in your family had any of the following? (Check appropriate box)

	Mother	Father	Maternal Grandparent	Paternal Grandparent	Brothers/ Sisters	Aunts/ Uncles	Details
Hypertension							
Osteoarthritis							
Osteoporosis							
Diabetes, Type 2							
Scoliosis							
Other:							

□ No Family History (checking this box indicates no past family medical history)

Review of Systems

Please check yes or no if you are currently experiencing any of the following.

Symptoms	Yes	No	Symptoms	Yes	No
Joint pains			Fever		
Joint swelling			Chills		
Joint stiffness			Poor healing wounds		
Unsteady Gait			Scarring/Keloids		
Numbness			Easy bleeding		
Tingling			Unexpected weight loss		

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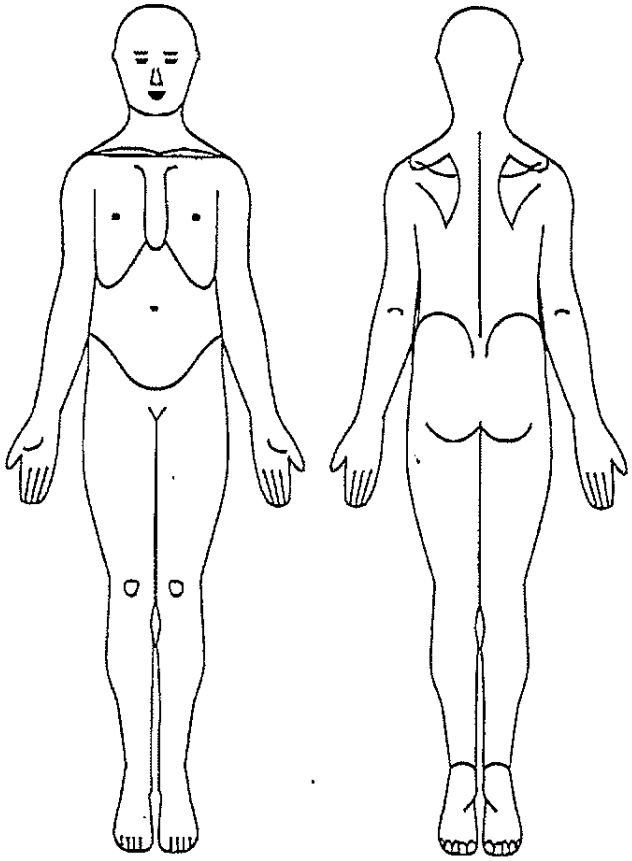
Alerts

Please check yes or no for any of the following.

Alert	Yes	No	Alert	Yes	No
Pacemaker			RSD		
Blood thinners			Allergy to shellfish/iodine		
Defibrilator			Allergy to latex		
Premedication prior to procedure			Allergy to adhesive		
Rheumatoid arthritis			Under pain management		

PLEASE CIRCLE WHAT BODY PARTS YOU HAVE ISSUES WITH



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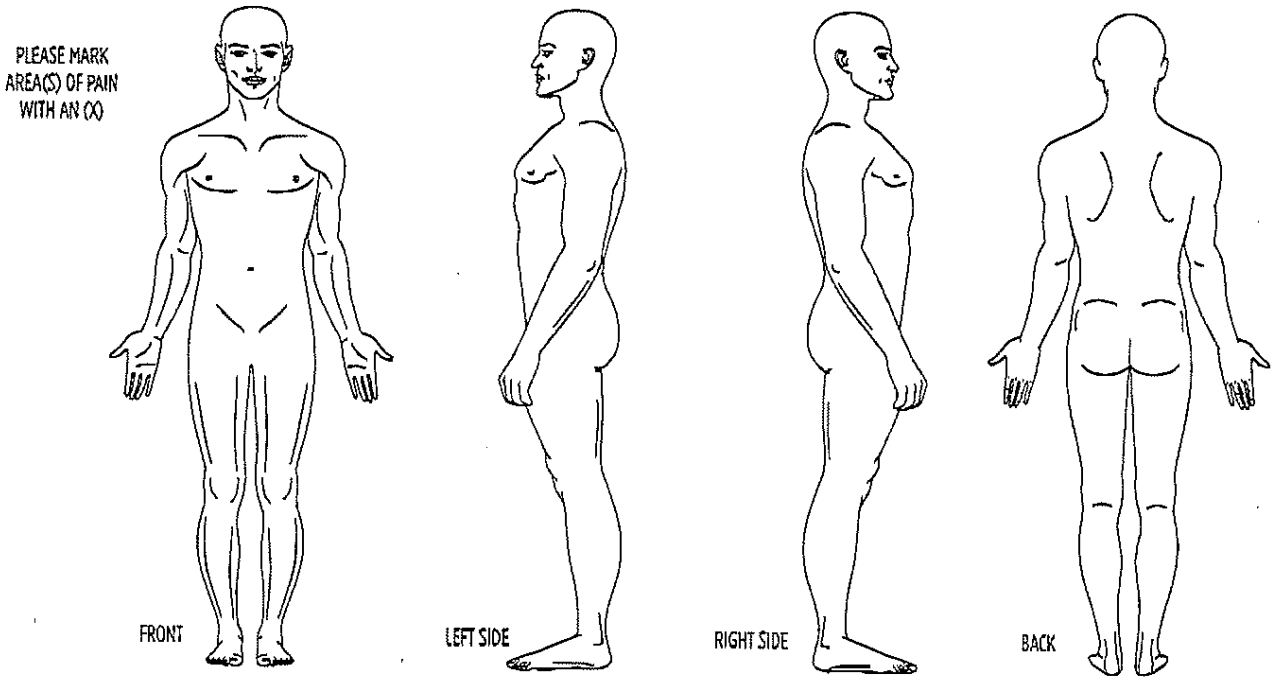
General Pain Evaluation

Circle a number below to indicate your usual pain intensity over the past week.

0	1	2	3	4	5	6	7	8	9	10
No Pain		Mild Pain		Moderate Pain			Severe Pain			Excruciating Pain



What makes the pain **WORSE**? Please be specific.

What makes the pain BETTER? Please be specific.

Effects of Pain:

Circle the number to indicate how much your pain has interfered with your activities this **past week.**

0	1	2	3	4	5	6	7	8	9	10
No Pain		Mild Pain		Moderate Pain			Severe Pain			Excruciating Pain

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Describe, in your own words, the pain problem (s) that you would like help with.

_____

_____

_____

Below is a list of words that may describe your pain. Please rate each word by placing a check mark in the column that best describes the intensity of that type of pain.

	None	Mild	Moderate	Severe		None	Mild	Moderate	Severe
Throbbing					**Heavy**				
Shooting					**Tender**				
Stabbing					**Splitting**				
Cramping					**Tiring - Exhausting**				
Gnawing					**Sickening**				
Hot-Burning					**Fearful**				
Aching					**Punishing-Cruel**				
Sharp									

Is your pain □ Continuous or □ Intermittent?

If your pain is intermittent, how often does it occur?

□ Several times a day □ Several times per week □ Less than once per week □ Once per day □ Once per week □ Never

□ Other: _____

How long does your pain last? □ None □ Seconds □ Minutes □ Hours □ Days □ Weeks

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Who Presents this Notice

This Notice describes the privacy practices of Brookwood Baptist Health, Primary Care Network and members of its workforce, as well as the physician members of the medical staff and allied health professionals who practice at the Practice. The Practice and the individual health care providers together are sometimes called "the Practice and Health Professionals" in this Notice. While the Practice and Health Professionals engage in many joint activities and provide services in a clinically integrated care setting, the Practice and Health Professionals each are separate legal entities. This Notice applies to services furnished to you at the Practice as a Practice patient or any other services provided to you in a Practice-affiliated program involving the use or disclosure of your health information.

Privacy Obligations

The Practice and Health Professionals each are required by law to maintain the privacy of your health information ("Protected Health Information" or "PHI") and to provide you with this Notice of legal duties and privacy practices with respect to your Protected Health Information. The Practice and Health Professionals use computerized systems that may subject your Protected Health Information to electronic disclosure for purposes of treatment, payment and/or health care operations as described below. When the Practice and Health Professionals use or disclose your Protected Health Information, the Practice and Health Professionals are required to abide by the terms of this Notice (or other notice in effect at the time of the use or disclosure).

Permissible Uses and Disclosures Without Your Written Authorization

In certain situations your written authorization must be obtained in order to use and/or disclose your PHI. However, the Practice and Health Professionals do not need any type of authorization from you for the following uses and disclosures:

Uses and Disclosures for Treatment, Payment and Health Care Operations. Your PHI, may be used and disclosed to treat you, obtain payment for services provided to you and conduct “health care operations” as detailed below:

- Treatment. Your PHI may be used and disclosed to provide treatment and other services to you--for example, to diagnose and treat your injury or illness. In addition, you may be contacted to provide you appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. Your PHI may also be disclosed to other providers involved in your treatment. For example, a doctor treating you for a broken leg may need to know if you have diabetes because if you do, this may impact your recovery.

- Payment. Your PHI may be used and disclosed to obtain payment for services provided to you--for example, disclosures to claim and obtain payment from your health insurer, HMO, or other company that arranges or pays the cost of some or all of your health care (“Your Payor”) to verify that Your Payor will pay for health care. The physician who reads your x-ray may need to bill you or your Payor for reading of your x-ray therefore your billing information may be shared with the physician who read your x-ray.

- Health Care Operations. Your PHI may be used and disclosed for health care operations, which include internal administration and planning and various activities that improve the quality and cost effectiveness of the care delivered to you. For example, PHI may be used to evaluate the quality and competence of physicians, nurses and other health care workers. PHI may be disclosed to the Practice Compliance & Privacy Office in order to resolve any complaints you may have and ensure that you have a comfortable visit. Your PHI may be provided to various governmental or accreditation entities such as the Joint Commission on Accreditation of Healthcare Organizations to maintain our license and accreditation. In addition, PHI may be shared with business associates who perform treatment, payment and health care operations services on behalf of the Practice and Health Professionals.

Use or Disclosure for Directory of Individuals in the Practice. The Practice may include your name, location in the Practice, general health condition and religious affiliation in a patient directory without obtaining your authorization *unless* you object to inclusion in the directory. Information in the directory may be disclosed to anyone who asks for you by name. Your religious affiliation may be given to a member of the clergy, such as a priest or minister, even if they do not ask for you by name. If you do not wish to be included in the facility directory, you will be given an opportunity to object at the time of admission.

Disclosure to Relatives, Close Friends and Other Caregivers. Your PHI may be disclosed to a family member, other relative, a close personal friend or any other person identified by you who is involved in your health care or helps pay for your care. If you are not present, or the opportunity to agree or object to a use or disclosure cannot practicably be provided because of your incapacity or an emergency circumstance, the Practice and/or Health Professionals may exercise professional judgment to determine whether a disclosure is in your best interests. If information is disclosed to a family member, other relative or a close personal friend, the Practice and/or Health Professionals would disclose only information believed to be directly relevant to the person's involvement with your health care or payment related to your health care. Your PHI also may be disclosed in order to notify (or assist in notifying) such persons of your location or general condition.

Public Health Activities. Your PHI may be disclosed for the following public health activities: (1) to report health information to public health authorities for the purpose of preventing or controlling disease, injury or disability; (2) to report child abuse and neglect to public health authorities or other government authorities authorized by law to receive such reports; (3) to report information about products and services under the jurisdiction of the U.S. Food and Drug Administration; (4) to alert a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition; and (5) to report information to your employer as required under laws addressing work-related illnesses and injuries or workplace medical surveillance.

Victims of Abuse, Neglect or Domestic Violence. Your PHI may be disclosed to a governmental authority, including a social service or protective services agency, authorized by law to receive reports of such abuse, neglect, or domestic violence if there is a reasonable belief that you are a victim of abuse, neglect or domestic violence.

Health Oversight Activities. Your PHI may be disclosed to a health oversight agency that oversees the health care system and is charged with responsibility for ensuring compliance with the rules of government health programs such as Medicare or Medicaid.

Judicial and Administrative Proceedings. Your PHI may be disclosed in the course of a judicial or administrative proceeding in response to a legal order or other lawful process.

Law Enforcement Officials. Your PHI may be disclosed to the police or other law enforcement officials as required or permitted by law or in compliance with a court order or a grand jury or administrative subpoena. For example, your PHI may be disclosed to identify or locate a suspect, fugitive, material witness, or missing person or to report a crime or criminal conduct at the facility.

Correctional Institution. You PHI may be disclosed to a correctional institution if you are an inmate in a correctional institution and if the correctional institution or law enforcement authority makes certain requests to us.

Business Associates. Your PHI may be disclosed to business associates or third parties that the Practice and Health Professionals have contracted with to perform agreed upon services.

Decedents. Your PHI may be disclosed to a coroner or medical examiner as authorized by law.

Organ and Tissue Procurement. Your PHI may be disclosed to organizations that facilitate organ, eye or tissue procurement, banking or transplantation.

Research. Your PHI may be used or disclosed without your consent or authorization if an Institutional Review Board approves a waiver of authorization for disclosure.

Health or Safety. Your PHI may be used or disclosed to prevent or lessen a serious and imminent threat to a person's or the public's health or safety.

Specialized Government Functions. Your PHI may be disclosed to units of the government with special functions, such as the U.S. military, the U.S. Department of State under certain circumstances such as the Secret Service or NSA to protect, for example, the country or the President.

Workers' Compensation. Your PHI may be disclosed as authorized by and to the extent necessary to comply with state law relating to workers' compensation or other similar programs.

As Required by Law. Your PHI may be used and disclosed when required to do so by any other law not already referred to in the preceding categories; such as required by the FDA, to monitor the safety of a medical device.

Appointment Reminders. Your PHI may be used to tell or remind you about appointments.

Fundraising. Your PHI may be used to contact you as a part of fundraising efforts, unless you elect not to receive this type of information.

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USES AND DISCLOSURES REQUIRING YOUR WRITTEN AUTHORIZATION

Use or Disclosure with Your Authorization. For any purpose other than the ones described above, your PHI may be used or disclosed only when you provide your written authorization on an authorization form ("Your Authorization"). For instance, you will need to execute an authorization form before your PHI can be sent to your life insurance company or to the attorney representing the other party in litigation in which you are involved.

Marketing. Your written authorization ("Your Marketing Authorization") also must be obtained prior to using your PHI to send you any marketing materials. (However, marketing materials can be provided to you in a face-to-face encounter without obtaining Your Marketing Authorization. The Practice and/or Health Professionals are also permitted to give you a promotional gift of nominal value, if they so choose, without obtaining Your Marketing Authorization). The Practice and/or Health Professionals may communicate with you in a face-to-face encounter about products or services relating to your treatment, case management or care coordination, or alternative treatments, therapies, providers or care settings without Your Marketing Authorization.

In addition, the Practice and/or Health Professionals may send you treatment communications, unless you elect not to receive this type of communication, for which the Practice and/or Health Professionals may receive financial remuneration.

Sale of PHI. The Practice and Health Professionals will not disclose your PHI without your authorization in exchange for direct or indirect payment except in limited circumstances permitted by law. These circumstances include public health activities; research; treatment of the individual; sale, transfer, merger or consolidation of the Practice; services provided by a business associate, pursuant to a business associate agreement; providing an individual with a copy of their PHI; and other purposes deemed necessary and appropriate by the U.S. Department of Health and Human Services (HHS).

Uses and Disclosures of Your Highly Confidential Information. In addition, federal and state law require special privacy protections for certain highly confidential information about you ("Highly Confidential Information"), including the subset of your PHI that: (1) is maintained in psychotherapy notes; (2) is about mental illness, mental retardation and developmental disabilities; (3) is about alcohol or drug abuse or addiction; (4) is about HIV/AIDS testing, diagnosis or treatment; (5) is about communicable disease(s), including venereal disease(s); (6) is about genetic testing; (7) is about child abuse and neglect; (8) is about domestic abuse of an adult; or (9) is about sexual assault. In order for your Highly Confidential Information to be disclosed for a purpose other than those permitted by law, your written authorization is required.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

Right to Request Additional Restrictions. You may request restrictions on the use and disclosure of your PHI (1) for treatment, payment and health care operations, (2) to individuals (such as a family member, other relative, close personal friend or any other person identified by you) involved with your care or with payment related to your care, or (3) to notify or assist in the notification of such individuals regarding your location and general condition. While all requests for additional restrictions will be carefully considered, the Practice and Health Professionals are not required to agree to these requested restrictions.

You may also request to restrict disclosures of your PHI to your health plan for payment and healthcare operations purposes (and not for treatment) if the disclosure pertains to a healthcare item or service for which you paid out-of-pocket in full. The Practice and Health Professionals must agree to abide by the restriction to your health plan EXCEPT when the disclosure is required by law.

If you wish to request additional restrictions, please obtain a request form from the Practice and submit the completed form to the Practice. A written response will be sent to you.

Right to Receive Confidential Communications. You may request, and the Practice and Health Professionals will accommodate, any reasonable written request for you to receive your PHI by alternative means of communication or at alternative locations.

Right to Revoke Your Authorization. You may revoke Your Authorization, Your Marketing Authorization or any written authorization obtained in connection with your PHI, except to the extent that the Practice and/or Health Professionals have taken action in reliance upon it, by delivering a written revocation statement to the Practice identified below.

Right to Inspect and Copy Your Health Information. You may request access to your medical record file and billing records maintained by the Practice and Health Professionals in order to inspect and request copies of the records. Under limited circumstances, you may be denied access to a portion of your records. If you desire access to your records, please obtain a record request form from the Practice and submit the completed form to the Practice. If you request copies of paper records, you will be charged in accordance with federal and state law. To the extent the request for records includes portions of records which are not in paper form (e.g., x-ray films), you will be charge the reasonable cost of the copies. You also will be charged for the postage costs, if you request that the copies be mailed to you. However, you will not be charged for copies that are requested in order to make or complete an application for a federal or state disability benefits program.

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Right to Amend Your Records. You have the right to request that PHI maintained in your medical record file or billing records be amended. If you desire to amend your records, please obtain an amendment request form from the Practice and submit the completed form to the Practice. Your request will be accommodated unless the Practice and/or Health Professionals believe that the information that would be amended is accurate and complete or other special circumstances apply.

Right to Receive an Accounting of Disclosures. Upon request, you may obtain an accounting of certain disclosures of your PHI made during any period of time prior to the date of your request provided such period does not exceed six years and does not apply to disclosures that occurred prior to April 14, 2003. If you request an accounting more than once during a twelve (12) month period, you will be charged for the accounting statement.

Right to Receive Paper Copy of this Notice. Upon request, you may obtain a paper copy of this Notice, even if you have agreed to receive such notice electronically.

For Further Information or Complaints. If you desire further information about your privacy rights, are concerned that your privacy rights have been violated or disagree with a decision made about access to your PHI, you may contact the Practice Compliance & Privacy Office. You may also file written complaints with the Director, Office for Civil Rights of the U.S. Department of Health and Human Services. Upon request, the Practice Compliance & Privacy Office will provide you with the correct address for the Director. The Practice and Health Professionals will not retaliate against you if you file a complaint with the Practice Privacy Office or the Director.

Effective Date and Duration of This Notice

Effective Date. This Notice is effective on **September 23, 2013.**

Right to Change Terms of this Notice. The terms of this Notice may be changed at any time. If this Notice is changed, the new notice terms may be made effective for all PHI that the Practice and Health Professionals maintain, including any information created or received prior to issuing the new notice. If this Notice is changed, the new notice will be posted in waiting areas around the Practice and on our Internet site at www.bbhcarenetwork.com. You also may obtain any new notice by contacting the Practice Compliance & Privacy Office.

PRACTICE CONTACTS:

****WRITTEN HIPAA INQUIRIES ONLY****
Brookwood Baptist Health, Primary Care Network
Attn: John Melton
1130 22nd St S #1000
Birmingham, AL 35205
Telephone Number: (205) 986-1293

Corporate Compliance & Privacy Office
Tenet Healthcare
1445 Ross Avenue, Suite 1400
Dallas, Texas 75202
E-mail: PrivacySecurityOffice@tenethealth.com
Phone: 1-877-893-8363 ext. 2009
Ethics Action Line (EAL): 1-800-8-ETHICS