Brookwood Baptist Health

Specialty Care Network
Maternal Fetal Medicine

Patient Registration Form

Date: _____ Doctor: _____

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	

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	

HOW DID YOU HEAR ABOUT US? (CHECK ALL THAT APPLY)

☐ Television	☐ Event	☐ Signage	☐ Rating Website (Vitals, HealthGrades, etc.)	☐ Word of Mouth
☐ Radio	☐ Zoc Doc	☐ Physician Referral	☐ Search Engine (Google, Yahoo, etc.)	☐ Brookwood Medical Center Website
☐ Billboard	☐ Mailer	☐ Social Media	☐ Magazine/Newspaper Ad	☐ Brookwood Care Network Website

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 & Specialty Care Network, Inc. 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:**_____

Brookwood Baptist Health

Specialty Care Network
Maternal Fetal Medicine

Important Information for our Patients

- **Appointments**
  - Your appointment time is dedicated to you. It is important to your health that you show up for your appointment.
  - Our office is committed to running on time, please show up as instructed.
    1. New patients - 30 minutes if you need to fill out paperwork
    2. New patients - 15 minutes if you bring the completed paperwork with you
    3. Returning patients - 10-15 minutes early
  - Please call us if you need to reschedule or cancel for any reason, a 24-hour notice is best.
  - **If you are late**, you may be asked to reschedule.
- **Insurance**
  - If you have Medicaid
    1. Bring your card; if you do not have your ID card, bring your approval letter
    2. Photo ID

    If you are denied Medicaid, you will be billed for services

  - If you have Blue Cross Blue Shield with any of the following prefixes
    1. BEG
    2. PGX
    3. BGL

    PLEASE make sure your **Primary Care Physician** has made an insurance referral to Dr. Antonio R. Gonzalez-Ruiz or your care may be denied and you will be billed for all services.

  - Maternal-Fetal Medicine bills your insurance as you come. We do not wait for delivery. All co-pays, co-insurance, deductibles and out-of-pocket expenses are due at the time of service. We do our best to estimate the amount but there are times we may bill you after the visit.
  - If your insurance requires any information from you, please respond promptly or we will have no choice but to bill you.
  - If your insurance requires us to use a specific Laboratory, please let us know in advance.
  - The practice does turn over delinquent accounts to Holloway Collection Service.

_____ _____

Patient Name Date

Brookwood Baptist Health

Specialty Care Network
Maternal Fetal Medicine

Consent for the Release of Medical Information to Specified Individuals

Brookwood Baptist Health, Primary & Specialty Care Network, Inc. is committed to the protection of our patient's personal health information. However, we recognize that individuals other than themselves attend to many of our patient's healthcare needs. In accordance with new HIPAA regulations, we ask that you take a moment to give us the names of individuals with whom we are able to discuss your medical appointments, condition, treatment options, insurance payment information, or other information necessary to our responsibility in your treatment. Please list the names (and phone numbers, if readily available) of any individuals with whom we may have communication, which may include all, or part of your personal health information. If you fail to list any names, we will not discuss your medical information with anyone other than yourself.

Examples include: spouse, parent, child, brother/sister, friend, etc.

Patient's signature:_____ Date: _____

Contact/Relationship to patient: Telephone Number:

1. _____ _____

2. _____ _____

3. _____ _____

( ) Home answering machine message only

( ) Voicemail message only

( ) Cell/Pager # _____

Brookwood Baptist Health

Specialty Care Network
Maternal Fetal Medicine

Patient Consent for the Use and Disclosure Of Protected Health Information

I hereby give my consent for BROOKWOOD BAPTIST HEALTH, PRIMARY & SPECIALTY CARE NETWORK, INC. to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). (BROOKWOOD BAPTIST HEALTH, PRIMARY & SPECIALTY CARE NETWORK, INC.'S Notice of Privacy Practices provides a more complete description of such uses and disclosures.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. BROOKWOOD BAPTIST HEALTH, PRIMARY & SPECIALTY CARE NETWORK, INC. reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to John Melton, Privacy Officer at Brookwood Baptist Health, Primary & Specialty Care Network, Inc. – 1500 Urban Center Drive, Suite 450, Vestavia Hills, AL 35242.

With this consent, BROOKWOOD BAPTIST HEALTH, PRIMARY & SPECIALTY CARE NETWORK, INC. may call my home or other alternative location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminder, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, BROOKWOOD BAPTIST HEALTH, PRIMARY & SPECIALTY CARE NETWORK, INC. may email to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that BROOKWOOD BAPTIST HEALTH, PRIMARY & SPECIALTY CARE NETWORK, INC. restrict how it uses or discloses my PHI to carry out TPO.

However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to BROOKWOOD BAPTIST HEALTH, PRIMARY & SPECIALTY CARE NETWORK, INC.'s use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, BROOKWOOD BAPTIST HEALTH, PRIMARY & SPECIALTY CARE NETWORK, INC. may decline to provide treatment to me.

_____

Signature of Patient or Legal Guardian

_____ _____

Patient's Name Date

_____

Print Name of Patient or Legal Guardian

Brookwood Baptist Health

Specialty Care Network
Maternal Fetal Medicine

Videotaping Prohibited

Brookwood Maternal Fetal Medicine does not allow Videotaping of Ultrasounds.

"Videotaping of any type is prohibited during the patient's ultrasound and/or during the exam."

Your signature on this form indicates that you have read and understood the information provided in this form:

_____
Signature of Patient

_____ _____
Patient's Name Date

Brookwood Baptist Health

Specialty Care Network
Maternal Fetal Medicine

Payment Policy

Thank you for selecting the Brookwood Care Network. We are committed to providing you with high quality and affordable health care. Due to recent changes in healthcare plans, some of our patients have had questions regarding patient and insurance responsibility for services rendered. Please read our payment policy, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. **Insurance**. We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, you will need to have a current card so that we may verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. **Co-payments and deductibles**. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment and/or deductible at each visit.

3. **Coverage changes**. If your insurance changes, please notify us before or on your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay within 30 days you will be responsible for the balance.

Our Practice is committed to providing the best treatment to our patients. Our rates are representative of the usual and customary charges for our area. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

_____ _____

Signature of patient or responsible party Date

Brookwood Baptist Health

Specialty Care Network
Maternal Fetal Medicine

Patient's Name: _____ Date: _____

Preferred Pharmacy: _____ Phone/Location: _____

Allergies:

Medication	**Reaction**

Prescriptions:

Medication	**Dose**	**How do you take it?**

Over the counter medications:

(Please include medications you take regularly, vitamins, and herbal supplements)

Medication	**Dose**	**How do you take it?**

Brookwood Baptist Health

Specialty Care Network
Maternal Fetal Medicine

Patient History

Patient's Name: _____ Date: _____ Age: _____

Number of pregnancies including the present one: _____

Number of live births: _____

Number of pregnancies delivered at full term: _____

Number of premature births: _____

Number of miscarriages: _____

Number of abortions: _____

Number of tubal pregnancies: _____

Date that your last period began: _____

Present Problem

What is the reason you have come to see the doctor: _____

_____

_____

_____

Obstetric History

Is this your first Pregnancy? YES _____ NO _____

If the answer is "NO" please describe **ALL** your pregnancies including miscarriages, abortions, and tubal pregnancies. Start with your first pregnancy. Do not include information about the present pregnancy.

Number 1. Date of Delivery _____ How many weeks or months at the time of delivery? _____

Labor induced _____ or spontaneous _____

Duration of labor _____ Type of anesthesia _____

Complications during the pregnancy _____

Complications at delivery _____

Newborn sex: _____ Newborn weight: _____

Hospital where delivery took place _____

Number 2. Date of Delivery _____ How many weeks or months at the time of delivery? _____

Labor induced _____ or spontaneous _____

Duration of labor _____ Type of anesthesia _____

Complications during the pregnancy _____

Complications at delivery _____

Newborn sex: _____ Newborn weight: _____

Hospital where delivery took place _____

Number 3. Date of Delivery _____ How many weeks or months at the time of delivery? _____

Labor induced _____ or spontaneous _____

Duration of labor _____ Type of anesthesia _____

Complications during the pregnancy _____

Complications at delivery _____

Newborn sex: _____ Newborn weight: _____

Hospital where delivery took place _____

Number 4. Date of Delivery _____ How many weeks or months at the time of delivery? _____

Labor induced _____ or spontaneous _____

Duration of labor _____ Type of anesthesia _____

Complications during the pregnancy _____

Complications at delivery _____

Newborn sex: _____ Newborn weight: _____

Hospital where delivery took place _____

Medical History

Have you had any of the following medical conditions?

YES	NO	
_____	_____	Asthma
_____	_____	AIDS
_____	_____	Anemia
_____	_____	Arthritis
_____	_____	Bleeding disorders
_____	_____	Bowel disorders/colitis
_____	_____	Bronchitis/emphysema
_____	_____	Chicken Pox
_____	_____	Cancer/Tumors
_____	_____	Diabetes
_____	_____	Epilepsy (seizures)
_____	_____	Gallbladder/Gallstones
_____	_____	Glaucoma
_____	_____	Headaches/Migraines
_____	_____	Heart trouble/Heart Murmur
_____	_____	Hepatitis (yellow jaundice)/liver problems
_____	_____	High Blood Pressure
_____	_____	Infertility
_____	_____	Kidney or bladder trouble, urinary tract infections
_____	_____	Nervous/emotional problems/depression
_____	_____	Rheumatic fever
_____	_____	Sexual abuse/Rape
_____	_____	Stomach problems/ulcers
_____	_____	Stroke or paralysis
_____	_____	Tuberculosis
_____	_____	Thyroid gland disease/goiter

Brookwood Baptist Health

Specialty Care Network
Maternal Fetal Medicine

Have you ever received a blood transfusion or blood products? YES _____ NO _____

If "YES" please give date and reason for the transfusion _____

List any other serious illnesses or injuries you have had (give dates): _____

_____

_____

_____

Have you ever had surgery? YES _____ NO _____

If "YES", please give dates and reason for the operation(s):

_____

_____

_____

Gynecologic History

Age at onset of menstrual cycle: _____ Days between periods: _____

Duration of menstrual bleeding: _____ Age at the time of first sexual relation: _____ Number of partners: _____

Have you ever had abnormal pap smears: YES NO If "YES", when? _____ Did you have treatment: YES NO

Have you had any sexually transmitted disease (herpes, syphilis, Chlamydia, trichomonas, venereal warts, etc.) YES NO

If "YES", when? _____ Did you receive treatment? YES NO

Social History

Married: _____ Single: _____ Divorced: _____

Do you smoke? YES NO If yes, how many cigarettes per day? _____

Do you drink? YES NO If yes, how many drinks per week? _____

Do you use street drugs? YES NO If yes, when was the last use? _____

What kind of drug? _____ Amount? _____

What is the age of the baby's father? _____ Is he involved? YES NO

Is there a history or sexual, physical or verbal abuse? YES NO

Brookwood Baptist Health

Specialty Care Network
Maternal Fetal Medicine

Family History

Has anyone in your family had any of the following medical conditions?

Condition	**Relationship**
Diabetes	
High Blood pressure	
Heart Disease	
Strokes	
Epilepsy	
Kidney disease	
Blood clots	
Toxemia of pregnancy	

Patient, baby's father, or anyone in the family with:

	YES	**NO**
Patient's age equal or older than 35		
Italian, Greek, Mediterranean or Oriental background		
Neural tube defect (open spine)		
Down syndrome		
Jewish ancestry		
Sickle Cell		
Hemophilia		
Muscular Dystrophy		
Cystic Fibrosis		
Huntington's chorea		
Mental Retardation		
Was person tested for Fragile X?		
Patient or baby's father has a child with Birth defect not listed above?		

Brookwood Baptist Health

Specialty Care Network
Maternal Fetal Medicine

Review of Systems

Have you ever had any of the following:

YES	NO	
_____	_____	Unexpected weight change of more than 10 lbs in the last year?
_____	_____	Any serious problems with your eyes or ears?
_____	_____	Any persistent swollen glands or unusual lumps?
_____	_____	Any breast lumps or nipple discharge?
_____	_____	Your heart frequently racing or skipping beats?
_____	_____	Unusual or severe shortness of breath?
_____	_____	Frequent swelling of ankles, hands or face?
_____	_____	Inflamed veins or clots in your veins?
_____	_____	Is your skin very sensitive to the sun light?
_____	_____	Frequent coughing or wheezing?
_____	_____	Serious difficulties swallowing?
_____	_____	Frequent or severe stomach or abdominal pain?
_____	_____	Frequent nausea or vomiting?
_____	_____	Severe constipation or diarrhea?
_____	_____	Blood in the stool or black stools?
_____	_____	Unusual skin problems or persistent sores?
_____	_____	Redness, severe pain or swelling of your joints?
_____	_____	Frequent or severe back pain?
_____	_____	Do you bruise easily?
_____	_____	Have you ever had a severe head injury?
_____	_____	Have you ever lost consciousness?
_____	_____	Have you ever broken any bones?
_____	_____	Have you ever had abnormal periods?
_____	_____	Have you ever had vaginal infections?
_____	_____	Have you ever had serious sexual difficulties?
_____	_____	Have you had or do you have serious problems at home or work?
_____	_____	Have you ever been exposed to poisons, fumes, toxins or chemicals, smoke, radioactive materials at home or work?

Do you have religious beliefs that preclude you from receiving certain medical care?

YES _____ **NO** _____

What is your present weight? _____

What was your weight before you became pregnant? _____

How tall are you? _____

Brookwood Baptist Health

Specialty Care Network
Maternal Fetal Medicine

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 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.

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.

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 & Specialty Care Network
1500 Urban Center Drive, Suite 450
Vestavia Hills, AL 35242
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