Brookwood Baptist Health
Primary & Specialty Care Network

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	

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	Employer	

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)

☐ 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 & Specialty 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:**____

Brookwood Baptist Health
Primary & Specialty Care Network

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.

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: ____________________

Brookwood Baptist Health

Primary & Specialty Care Network

NOTICE OF PRIVACY PRACTICES (NPP) ACKNOWLEDGMENT

A Notice of Privac y Practices (NPP) is provided to all patients. This Notice of Privacy Practices identifies: 1) how medical information about you may be used or disclosed ;2) your rights to access your medical information.amend your medical information, request an accounting of disclosures of your medical information, and request additional restrictions on our uses and disclosures of that information; 3) your rights to complain if you believe your privacy rights have been violated; and
4) Our responsibilities for maintaining the privacy of your medical information.

The undersigned certifies that he/she has read the foregoing, received a copy of the Notice of Privacy Practices and is the patient,or the patient's personal representative.

______________________________	______________________________
Name of Patient	Signature of Patient/Date Signed
Name Patient's Personal Representative	Signature of Patient's Personal Representative/Date Signed

---

FOR INTERNAL USE ONLY

______________________________	______________________________
Name of Employee	Signature of Employee

If applicable, reason patient's written acknowledgment could not be obtained:

O Patient was unable to sign.
O Patient refused to sign.
O Other:

Version 1 Effective Date: 2/1/2018

Notice of Privacy Practices (NPP) Acknowledgement

Insert additional Patient Information as needed.

Brookwood Baptist Health
Primary & Specialty Care Network

PATIENT COMMUNICATION CONSENT

We may need to contact you regarding your medical care, appointments, test results, referrals, or any other reason. This is to acknowledge that you authorize Brookwood Baptist Health to contact you and how you wish to be contacted (check all that apply):

	ORDER OF PREFERENCE:	OK TO LEAVE VOICEMAIL?	PHONE NUMBER:
HOME PHONE	❐1 ❐2 ❐3 ❐4 ❐5	❐YES ❐NO	
CELL PHONE	❐1 ❐2 ❐3 ❐4 ❐5	❐YES ❐NO	
WORK PHONE	❐1 ❐2 ❐3 ❐4 ❐5	❐YES ❐NO	
ALTERNATE PHONE	❐1 ❐2 ❐3 ❐4 ❐5	❐YES ❐NO	
PATIENT PORTAL & SECURE EMAIL	❐1 ❐2 ❐3 ❐4 ❐5	EMAIL ADDRESS:	
□ None of the above			

PHI DISCLOSURE TO FAMILY MEMBERS

You may authorize us to contact a family member regarding your medical care or financial matters. This is to acknowledge that you authorize Brookwood Baptist Health to disclose your PHI to the following individuals (check all that apply):

Name:____ **Relationship to Patient:** ____________________
Telephone: (__________)________________ **Email:**____ **Types of Information:** ❐ Appointment Reminders ❐ Results (lab test, X-Ray, etc) ❐ Financial ❐ Other: ____________
Okay to contact via: ❐ Telephone ❐ Leave a Voice Mail ❐ Patient Portal & Secure Email ❐ Other: ________________

Name:____ **Relationship to Patient:** ____________________
Telephone: (__________)________________ **Email:**____ **Types of Information:** ❐ Appointment Reminders ❐ Results (lab test, X-Ray, etc) ❐ Financial ❐ Other: ____________
Okay to contact via: ❐ Telephone ❐ Leave a Voice Mail ❐ Patient Portal & Secure Email ❐ Other: ________________

Name:____ **Relationship to Patient:** ____________________
Telephone: (__________)________________ **Email:**____ **Types of Information:** ❐ Appointment Reminders ❐ Results (lab test, X-Ray, etc) ❐ Financial ❐ Other: ____________
Okay to contact via: ❐ Telephone ❐ Leave a Voice Mail ❐ Patient Portal & Secure Email ❐ Other: ________________

□ **None of the above** **Signature/Date:** ____

Brookwood Baptist Health
Primary & Specialty Care Network

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.**

Brookwood Baptist Health
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Patient History

Name:______________________________Age:__________Date:________________

Main Complaint: ____

____

Allergies: List any medications to which you are allergic and how you are affected:

____

____

Medications: List all medications including vitamins and over-the-counter drugs you are now taking and the dosage if known

____

____

____

____

HAVE YOU HAD PROBLEMS WITH ANY OF THE FOLLOWING IN THE LAST SEVERAL MONTHS? (CIRCLE YES OR NO – PLEASE ANSWER ALL QUESTIONS)

HEENT:

Question			Question		
Headache or any pain in the head? How Frequent? ______________	Yes	No	Eye disease or problems? Type? ______________	Yes	No
History of migraine headaches? How Frequent? ______________	Yes	No	Double vision or ever see two objects at once?	Yes	No
			Blind spots or dark spots in field of vision?	Yes	No
Blackouts or fainting?	Yes	No			
Actually passed out?	Yes	No	Do you wear glasses?	Yes	No
			Do you wear contacts?	Yes	No
Dizziness or light-headedness?	Yes	No			
			Mouth soreness or dryness?	Yes	No
Allergies or sinus problems?	Yes	No			
			Difficulty swallowing or dryness?	Yes	No
History of sinus irrigation due to infection?	Yes	No			
			Throat soreness?	Yes	No
Nose Bleeds?	Yes	No	Throat hoarseness?	Yes	No
Change or decrease in hearing?	Yes	No	Any thyroid problems? Low or High (Please circle)	Yes	No
Ringing or roaring in ears?	Yes	No			

CV:

Question			Question		
Shortness of breath with activity?	Yes	No	History of pneumonia?	Yes	No
How far can you walk, regular pace, without getting shortness of breath? ________blocks or less distance ______________			Any chest pain? Sharp, dull, aching, shooting, knife-like? (Please circle one)	Yes	No
			Any chest pain – burning pressure or tightness?	Yes	No
Get short of breath when first lying down at night?	Yes	No			
			Heart skipping or fluttering?	Yes	No
Wake up short of breath during night after going to sleep?	Yes	No	History of high blood pressure?	Yes	No
			Ever been treated?	Yes	No

GI:

Heartburn? What do you take? ________________________	Yes	No	Constipation or hemorrhoids?	Yes	No
History of ulcers or stomach bleeding?	Yes	No	Abdominal cramps or any Abdominal pain? Upper Lower (please circle)	Yes	No
Indigestion? What do you take? ________________________	Yes	No	Abdominal pain with bowel movement?	Yes	No
Do certain foods bother you? What? ________________________	Yes	No	Do you use any type of laxative? What / how frequent? ________________________	Yes	No
Nausea or vomiting?	Yes	No	Weight gain or loss? (Circle which) How much? ________________________		
Change in bowel habits, stool, color, frequency, or any blood or diarrhea? (circle which)	Yes	No	History of gallstones or gallbladder problems?	Yes	No

GU:

Burning or pain with urination?	Yes	No	History of prostate disease or trouble?	Yes	No
Urine with blood, odor, darkening like tea or coke? (Please circle)	Yes	No	Lose urine with coughing or sneezing?	Yes	No
Trouble with urine stream, starting stream, dribbling, cutting off too soon? (Please circle)	Yes	No	How many times do you get up to void? ________________________	Yes	No

GYN (Women only):

Burning or pain with urination?	Yes	No	Date of last Pap smear ________________ Date of last mammogram ________________		
Do you have clots with periods? Cramps with period?	Yes Yes	No No	Do you have PMS symptoms? What? ________________________	Yes	No
Do you spot between periods? Date of last period ________________________	Yes	No	Do you perform self-breast exams?	Yes	No

ENDO:

Do you have a history of or have you been treated for abnormal blood sugar or diabetes? If yes, how and when? ________________________ ________________________	Yes	No	Are you on a diet? Type ________________________	Yes	No
			Do you exercise? Type ________________________	Yes	No
History of hormone or gland problems?	Yes	No	How frequently? ________ Day/Week		

MS:

Any joint aches or pains? Where? ________________________	Yes	No	Muscle cramps at night?	Yes	No
			Calf or leg cramps or pain when you walk?	Yes	No
Swelling of any joints? Where? ________________________	Yes	No	Skin rash, new skin growths or skin disease?	Yes	No
History of arthritis? What type? ________________________ Treatment? ________________________	Yes	No	Change in color of skin spots or moles? Any back, neck, or spine pain?	Yes Yes	No No

CNS:

Problems falling asleep or staying asleep?	Yes	No	Ever had panic episodes or panic attacks?	Yes	No
Change in appetite? If yes, too much or too little? (Please circle)	Yes	No	Worried? Any particular worries or special worries?	Yes	No
Nervous problems?	Yes	No	Any fears or special fear? Type ________________________	Yes	No
Been feeling down or depressed?	Yes	No	Any changes in sex drive? Type? ________________________	Yes	No
Anxious or nervous?	Yes	No	How long? ________________________		

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Last time you felt good ______________________

Are you looking forward to something in the future? Yes No

Do you wear seatbelts regularly? Yes No

Is there anything you would like to have discussed or tested by your doctor?

____

____

____

List any inhalants or insect stings to which you are allergic: ______________________________________

____

Surgery: List any previous surgery and the dates: ______________________________________

____

____

Have you received blood transfusions? Please circle Yes or No

Illnesses: List any previous and current medical illnesses: ______________________________________

____

____

SMOKING: Please circle Yes or No If yes, how many packs per day?______________for how many years? ______________

Smoked previously? Please circle Yes or No How much?______________ for how long? ______________

FAMILY HISTORY:

	Living?	Deceased?	
Father:	Living? Yes or No (Please circle) If yes, Age ___________	Deceased? Yes or No (Please circle) If yes, Age at death	Cause of death
Mother:	Living? Yes or No (Please circle) If yes, Age ___________	Deceased? Yes or No (Please circle) If yes, Age at death	Cause of death
Brothers:	Living? Yes or No (Please circle) If yes, Age ___________	Deceased? Yes or No (Please circle) If yes, Age at death	Cause of death
Sisters:	Living? Yes or No (Please circle) If yes, Age ___________	Deceased? Yes or No (Please circle) If yes, Age at death	Cause of death

Does anyone in your family have: (State whom)

Heart Trouble? ______________________ Tuberculosis? ______________________

Diabetes? ______________________ Strokes? ______________________

Inherited Diseases? ______________________ Cancer? ______________________

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PERSONAL HISTORY:

Age:__________________ Occupation: ____

Time with present employer:__________________ Do you primarily sit on your job? ______________________________

Spouse's age:__________________ Occupation: ____

Children's names and ages: ____

____

Hobbies: ____

Since your last check-up, have there been any births____________________deaths____________________big events______________________?

Patient Name:____ **DOB:** __________________________

Responsible Party Signature:____ **Date:** __________________________

Brookwood Baptist Health
Primary & Specialty Care Network

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 INFORMATON. PLEASE REVIEW IT CAREFULLY.

We are committed to protecting the confidentiality of your medical information, and are required by law to do so. This notice describes how we may use your medical information at Brookwood Baptist Health and how we may disclose it to others outside of Brookwood Baptist Health. This notice also describes the rights you have concerning your own medical information. Please review it carefully and let us know if you have questions.

For purposes of this notice, Brookwood Baptist Health includes the following:

Brookwood Baptist Health Primary & Specialty Care Network
Brookwood Baptist Health Physician Alliance
Shelby Baptist Ambulatory Surgery Center, LLC
Brookwood Baptist Medical Center
Citizens Baptist Medical Center
Princeton Baptist Medical Center
Shelby Baptist Medical Center
Walker Baptist Medical Center

Permissible Uses and Disclosures without Your Written Authorization

Treatment: We may use your medical information to provide you with medical services and supplies. We may also disclose your medical information to others who need that information to treat you, such as doctors, physician assistants, nurses, medical and nursing students, technicians, therapists, emergency service and medical transportation providers, medical equipment providers, and others involved in your care.

For example, we will allow other physicians treating you to have access to your medical record. To assure that your other treatment providers have quick access to your latest health information, we may participate in a community-based electronic health information exchange. We also may use and disclose your medical information to contact you to remind you of an upcoming appointment, to inform you about possible treatment options or alternatives, or to tell you about health-related services available to you, or to perform follow-up calls to monitor your care experience.

Family Members and Others Involved in Your Care: We may disclose your medical information to a family member or friend who is involved in your medical care, or to someone who helps to pay for your care. We also may disclose your medical information to disaster relief organizations to help locate a family member or friend in a disaster. During visits with family members and other visitors, let your physician and other personnel know if you do not want them to disclose your medical information during the visit.

Payment: We may use and disclose your medical information to get paid for the medical services and supplies we provide to you. For example, your health plan or Health Insurance Company may ask to see parts of your medical record before they will pay us for your treatment.

Health Care Operations: We may use and disclose your medical information if it is necessary to improve the quality of care we provide to patients or to run Brookwood Baptist Health. We may use your medical information to conduct quality improvement activities, to obtain audit, accounting or legal services, or to conduct business management and planning. For example, we may look at your medical record to evaluate the care provided by our personnel, your doctors, or other health care professionals.

Organized Health Care Arrangement: Each of the Brookwood Baptist Health hospitals have medical staff, which include physicians and other medical professionals who are not employees of the hospital. In addition, Brookwood Baptist Health Physician Alliance is an arrangement between Brookwood Baptist Health and physicians from each medical staff, including physicians employed by the Brookwood Baptist Health Primary & Specialty Care Network. These covered entities are participants in an organized health care arrangement, which permits protected health information to be shared for purposes of treatment, payment, and/or health care operations (as described above) relating to the organized health care arrangement.

Research: We may use or disclose your medical information for research projects, such as studying the effectiveness of a treatment you received. These research projects must go through a special process that protects the confidentiality of your medical information.

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. We also are required to give information to the State Workers' Compensation Program for work-related injuries.

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.

Public Health: We also may report certain medical information for public health purposes. For instance, we are required to report births, deaths, and communicable diseases to the State. We also may need to report patient problems with medications or medical products to the FDA, or may notify patients of recalls of products they are using.

Public Safety: We may disclose medical information for public safety purposes in limited circumstances. We may disclose medical information to law enforcement officials in response to a search warrant or a grand jury subpoena. We also may disclose medical information to assist law enforcement officials in identifying or locating a person, to prosecute a crime of violence, to report deaths that may have resulted from criminal conduct, and to report criminal conduct. We also may disclose your medical information to law enforcement officials and others to prevent a serious threat to health or safety.

Health Oversight Activities: We may disclose medical information to a government agency for oversight purposes, such as the State Department of Health, the federal agencies that oversee Medicare, the Board of Medical Examiners or the Board of Nursing. These agencies need medical information to monitor compliance with state and federal laws.

Coroners, Medical Examiners and Funeral Directors: We may disclose medical information concerning deceased patients to coroners, medical examiners and funeral directors to assist them in carrying out their duties.

Organ and Tissue Donation: We may disclose medical information to organizations that handle organ, eye or tissue donation or transplantation.

Military, Veterans, National Security and Other Government Purposes: If you are a member of the armed forces, we may release your medical information as required by military command authorities or to the Department of Veterans Affairs. We may also disclose medical information to federal officials for intelligence and national security purposes, or for presidential Protective Services.

Judicial Proceedings: We may disclose medical information if ordered to do so by a court or if we receive a subpoena or a search warrant. You will receive advance notice about this disclosure in most situations so that you will have a chance to object to sharing your medical information.

Uses and Disclosures for Which Your Authorization is Required: With limited exceptions, we must obtain your written authorization before we disclose your medical information in the following circumstances: (1) to disclose psychotherapy notes, (2) to conduct marketing activities, or (3) to sell your medical information to a third party.

Information with Additional Protection: Certain types of medical information have additional protection under state or federal law. For instance, medical information about communicable disease and HIV/AIDS, and evaluation and treatment for a serious mental illness is treated differently than other types of medical information. For those types of information, we are required to get your permission before disclosing that information to others in many circumstances.

Other Uses and Disclosures Requiring Authorization: If we wish to use or disclose your medical information for a purpose that is not discussed in this Notice, we will seek your written authorization. If you give your authorization, you may take back that authorization any time, unless we have already relied on your authorization to use or disclose the information. If you ever would like to revoke your authorization, please notify us in writing.

WHAT ARE YOUR RIGHTS?

Right to Request Your Medical Information: You have the right to look at your own medical information and to get a copy of that information. (The law requires us to keep the original record.) This includes your medical record, your billing record, and other records we use to make decisions about your care. To request your medical information, please contact the local facility where you receive care. Federal and state laws permit a reasonable cost-based fee to be charged for the copying of patient records. You will be notified in advance what this copying will cost. You can look at your record at no cost.

Right to Request Amendment of Medical Information You Believe Is Erroneous or Incomplete: If you examine your medical information and believe that some of the information is wrong or incomplete, you may ask us to amend your record. To ask us to amend your medical information, write to the local facility where you receive care.

Right to Get a List of Disclosures of Your Medical Information: You have the right to request a list of the disclosures we make of your medical information. If you would like to receive such a list, write to the local facility where you receive care. We will provide the first list to you free, but we may charge you for any additional lists you request during the same year. We will tell you in advance what this list will cost.

Right to Request Restrictions on How We Will Use or Disclose Your Medical Information for Treatment, Payment, or Health Care Operations: You have the right to request us from making uses or disclosures of your medical information to treat you, to seek payment for care, or to operate. In many cases, we are not required to agree to your request for restriction, but if we do agree, we will comply with that agreement. However, we must agree to your request not to disclose to your health plan any medical information about items or services for which you have paid in full, unless such disclosure is required for treatment or by law. If you do not want us to notify your health plan, you must notify us at the time of your registration as well as make immediate arrangements to pay in full for your treatment or visit.

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 facility and/or Health Professionals have taken action in reliance upon it, by delivering a written revocation statement to the local facility where you receive care.

Right to Request Confidential Communications: You have the right to ask us to communicate with you in a way that you feel is more confidential. For example, you can ask us not to call your home, but to communicate only by mail. To do this, write to the local facility where you receive care. At your request, you can also ask to speak with your health care providers in private outside the presence of other patients or family.

Right to a Paper Copy: If you have received this notice electronically, you have the right to a paper copy at any time. You may download a paper copy of the notice from our Web site, at **BBHCARENETWORK.COM,** or you may obtain a paper copy of the notice from the local facility where you receive care.

DUTIES OF BROOKWOOD BAPTIST HEALTH

We are required by law to protect the privacy of your medical information, give you this Notice of Privacy Practices, and follow the terms of the Notice that is currently in effect. We are also required to notify you if there is a breach of your unsecured medical information.

WHICH HEALTH CARE PROVIDERS ARE COVERED BY THIS NOTICE?

This Notice of Privacy Practices applies to Brookwood Baptist Health and its personnel, volunteers, students, and trainees.

CHANGES TO THIS NOTICE

From time to time, we may change our practices concerning how we use or disclose patient medical information, or how we will implement patient rights concerning their information. We reserve the right to change this Notice and to make the provisions in our new Notice effective for all medical information we maintain. If we change these practices, we will publish a revised Notice of Privacy Practices. You can get a

copy of our current notice of Privacy Practices at any time by contacting the local facility where you receive care.

DO YOU HAVE CONCERNS OR COMPLAINTS?

Please tell us about any problems or concerns you have with your privacy rights or how we use or disclose your medical information. If you have a concern, please contact the Ethics Action Line at 1-800-8-ETHICS.

If for some reason we cannot resolve your concern, you may also file a complaint with the Director, Office for Civil Rights of the U.S. Department of Health and Human Services. Upon request, the Privacy and Security Office will provide you with the correct address for the Director. We will not penalize you or retaliate against you in any way for filing a complaint with the federal government.

PRIVACY OFFICIAL CONTACT INFORMATION

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