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:**_____

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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

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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.

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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:** ____________________________________

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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

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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

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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?**

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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 _____

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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

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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

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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?		

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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? _____

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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 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