Brookwood Baptist Health

Primary & Specialty Care Network

Date:____________________________________

Doctor: __________________________________

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		

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	☐ Employee	☐ Rating Website	☐ Word of Mouth	☐ Tenet Employee
☐ Sign	☐ Zoc Doc	☐ Physician Referral	☐ Internet Search	☐ Insurance	☐ Urgent Care/ER
☐ Radio	☐ Postcard/flyer	☐ Social Media	☐ 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 & Specialty 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

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:** ____

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
Primary & Specialty Care Network

Patient History

Patient Name:____ Sex: □ Male □ Female Date: ____________________

Date of Birth:_______/______/___________Age:______________Cell Phone #:________________________Can we leave a message? □ Yes □ No

What is the reason for your visit today?

1. ____
2. ____
3. ____

Past Medical History

Check the conditions that doctors have followed you for in the past:

□ High blood pressure
□ High cholesterol
□ Liver disease
□ Diabetes ("sugar")
□ Thyroid problems
□ Kidney disease

□ Heart Attacks: Age _______
□ Heart Failure
□ Heart Murmur
□ Mitral Valve Prolapse
□ Stroke
□ Seizures/Epilepsy

□ Stomach Problems
□ Intestinal Problems
□ Reflux Disease
□ Arthritis
□ Osteoporosis
□ Anemia

□ Abnormal PAP
□ Bipolar Disorder
□ Depression
□ Anxiety
□ Low Back Pain
□ Migraine/headache

□ Cancer (type and location): ____

□ Other: ____

List all current medications (Dose & Frequency):

1. ____
2. ____
3. ____
4. ____
5. ____

List all current supplements (Dose & Frequency):

1. ____
2. ____
3. ____
4. ____
5. ____

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

____

List any drug allergies (What type of reaction? How severe?) □ None

____

Preventative Care

What year were these shots or tests given?

Tetanus Booster:________________Flu Shot:________________Pneumonia Vaccine:________________Hepatitis Vaccine: ________________

Colonoscopy:________________Shingles Vaccine (Age >60):________________Bone Density:________________PSA:________________

Female Only:

Last menstrual period:________________________Regular? □ Yes □ No Do you see an OB/GYN? ____________________________________

What do you use for birth control? □ Birth Control Pills □ Condoms □ IUD □ Vasectomy □ Ring/Diaphragm □ None

When was your last mammogram?_______________________________Results: □ Normal □ Abnormal

When was your last PAP smear?__________________________________Results: □ Normal □ Abnormal

Male Only:

Do you have problems with erections? ____

Brookwood Baptist Health

Primary & Specialty Care Network

When was your last prostate/rectal exam? ____________________

Name: **Social Habits**

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

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

Do you exercise regularly? What form? ____________________
Briefly describe your diet: ____________________
Marital Status: □ Married □ Single □ Separated □ Divorced □ Widowed
Are you sexually active with: □ 1 partner □ multiple partners □ with women □ with men □ none
Any history of sexually transmitted disease? (Type/year) ____________________
Who do you live with?____________________Do you feel safe at home? □ Yes □ No
If parent, what are the ages of your children? __________ __________ __________ __________ __________ __________
Briefly describe your diet: ____________________
Occupation: ____________________ Place of employment ____________________ Work Phone # ____________________
Your Pharmacy Name: ____________________ Address:____________________Tel #: ____________________

Family History

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

	Mother	Father	Maternal Grandparent	Paternal Grandparent	Brothers/ Sisters	Aunts/ Uncles	Details
Age (current or at death)							
High Blood Pressure							
MI/CVA (what age?)	Age:	Age:	Age:	Age:	Age:	Age:	
Diabetes							
Hyperlipidemia							
Cancer (type/location)							
Osteoporosis							
Depression/Dementia							Type:

Please check any of the following problems below that apply to you: □ No Problems

General
□ Fever
□ Sweats

Respiratory
□ Cough
□ Shortness of breath
□ Pneumonia
□ Wheezing
□ Shortness of breath with exertion_

Ear/Nose/Throat
□ Ear pain
□ Runny nose
□ Sneezing
□ Post nasal drip

Cardiovascular
□ Chest pain or pressure
□ Ankle swelling
□ Palpitations

Genitourinary
□ Urinary frequency
□ Burning with urination
□ Blood in urine
□ Problems urinating
□ Awaken at night to urinate #__________
□ Problems with sex
□ Exposure to sexually transmitted disease

Mental Health
□ Insomnia
□ Guilt
□ Depression
□ Anxiety
□ Suicidal thoughts

Skin
□ Rash
□ Changing mole
□ Itching
□ Slow healing wounds

Eyes
□ Blurred vision
□ Changing vision

Daily Living
□ Violence in your home
□ Changes in functional ability
□ Changes in eating habits
□ Changes in sleeping habits

Endocrine System
□ Excessive urination
□ Excessive thirst
□ Fatigue
□ Heat intolerance
□ Cold intolerance

Neurologic System
□ Numbness
□ Tingling
□ Headaches
□ Weakness

Allergy
□ Seasonal symptoms
□ Sneezing
□ Itchy eyes
□ Runny nose
□ Nasal congestion
□ Post nasal drip

Hematologic System
□ Easy bruising
□ Easy bleeding
□ Hard to stop bleeding_

Musculoskeletal
□ Joint swelling
□ Joint pains
□ Muscle pains

GI System
□ Nausea
□ Vomiting
□ Constipation
□ Abdominal pain
□ Diarrhea
□ Blood in stool

Nutrition
□ On a special diet
□ Weight gain or loss greater than 10 pound

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