St. Elizabeth PHYSICIANS

PATIENT REGISTRATION / Consent to Treat

Please print the information below and have your insurance card and legal photo ID available for the receptionist to scan.

PATIENT INFORMATION

Social Security # ___-___-_____ Last Name _____First Name _____ Middle ___

Address_____City _____St ____Zip _____

Home Phone (___)___-_____ Work Phone (___)____-_____ Ext. _____Email: _____

Date of Birth _____Marital Status _____ Race _____ Sex ___ Alternate Phone (___)____-_____

Emergency Contact _____Phone (_____)_____-_____
(Name) (Relationship)

Patient Employer _____ Emp. Address _____Emp. Phone (___)____-_____

Pharmacy most used by patient _____Pharm. Phone (____) ____-_____

Referring Provider (Specialist office only) _____

PERSON WHO SHOULD RECEIVE THE BILL - RESPONSIBLE PARTY (Guarantor)

Relationship to Patient: Self Parent Spouse Other _____

Social Security # ___-___-_____ Name _____

Address _____City _____St ____Zip_____

Home Phone (___)____-_____ Work Phone (___)____-_____Ext. _____Email: _____

Date of Birth _____Marital Status _____ Race _____ Sex ___ Alternate Phone (___)_____-_____

Employer _____ Emp. Address _____Emp. Phone (___)____-_____

PRIMARY INSURANCE COMPANY NAME_____**No Insurance**
(Circle if applicable)

Subscriber Relationship to Patient: Self Parent Spouse Other _____

Subscriber Name: _____Date of birth _____ SS# ___-___-_____

Employer _____PCP _____Copay _____

SECONDARY INSURANCE COMPANY NAME_____

Subscriber Relationship to Patient: Self Parent Spouse Other _____

Subscriber Name: _____Date of birth _____ SS# ___-___-_____

Employer _____ Copay _____

I understand that I am responsible for payment for all services rendered. I authorize St. Elizabeth Physicians to act as my agent in helping me obtain payment from my insurance companies. I authorize payment be made directly to St. Elizabeth Physicians. I authorize release of information to all my insurance companies which may be necessary to collect any payments. I further authorize release of medical information to any and all providers involved in my care. I permit a copy of this authorization to be used in the place of the original. I authorize the use of "signature on file" to be used on all of my insurance submissions. I understand that I am responsible for notifying the office of any precertification or referral needed for my insurance. According to recognized coding rules, you may receive separate charges for procedures, physicals and/or other problems during a single visit.

I further authorize the access of my clinical and medication information for treatment by my Primary or Specialty Care Provider and to any and all providers directly involved in my care.

Signature X_____ Date _____
(Signature of patient or patient representative)

Witness _____

St. Elizabeth PHYSICIANS

Notice of Privacy Practices
Effective Date: April 14, 2003
Effective Date: September 23, 2013

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

PLEASE REVIEW IT CAREFULLY.

Our Commitment to Your Privacy: We understand that medical information about you is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive to provide quality care and comply with legal requirements. This notice applies to all of the records of your care that we maintain. We are required by law to keep medical information about you private, to give you this notice of our legal duties and privacy practices with respect to medical information about you and to follow the terms of the notice that is currently in effect.

Organized Health Care Arrangement. St. Elizabeth Physicians participates in a clinically integrated care setting in which patients typically receive health care from more than one health care provider. This arrangement is called an Organized Health Care Arrangement (or OHCA) under the federal laws governing the privacy of patient health information. This means that when you receive services at St. Elizabeth Physicians, you may receive certain professional services from physicians on our Medical Staff, residents, and/or medical students who are independent practitioners and not employees or agents of St. Elizabeth Physicians. These independent practitioners have agreed to abide by the terms of this Notice when providing services at St. Elizabeth Physicians. Therefore, this Notice applies to all of your health information that is created or received as a result of being a patient at St. Elizabeth Physicians.

Who will follow this notice? The privacy practices in this notice will be followed by any health care professional that treats you at any of our locations, by all departments and units of our organization and by all employed associates.

Changes to this Notice. We may change our policies at any time. Changes will apply to information we already hold, as well as new information after the change occurs. If we make a material change in our policies that affects this notice, we will change our notice and post the new notice in our facilities and on our Web site at *www.stelizabethphysicians.com*. You may receive a copy of the current notice at any time. The effective dates are listed just below the title. You will be offered a copy of the current notice when you register. You will also be asked to acknowledge in writing that you were offered the notice.

How we may use and disclose medical information about you. Under certain circumstances, we are entitled to use or disclose your medical information without obtaining your written authorization. Some examples of when we are permitted to do this are presented below:

Treatment. We will use or disclose medical information about you for treatment purposes to doctors, nurses, technicians, and other caregivers in accordance with the Medical Authorization and Release that you signed and provided to us. We will make health information about you available through an electronic medical record system to healthcare providers who treat you. For example, your primary care provider may refer you to a specialist who will need to know about your medical conditions in order to treat you appropriately. A nurse or diabetic counselor may discuss your medical condition with your physician.

Payment. We will use and disclose your medical information as necessary for payment purposes, in accordance with the Medical Authorization and Release that you signed and provided to us. For instance, we may forward information regarding your medical treatment to your insurance company to arrange payment for the services provided to you or we may use your information to prepare a bill to send to you or to the person responsible for your payment. We may use and disclose your medical information to another entity or health care provider for payment of the entity that receives the information. For instance, we may forward information to your insurance company so they can prepare a bill.

Health Care Operations. We may use and disclose medical information about you to support our health care operations. For example, we may use or disclose your medical information in order for us to review our services and to evaluate our staff's performance. We may also use or disclose your medical information to obtain a medical consultation regarding your care or treatment.

Unless you tell us otherwise, we may disclose your medical information to a family member, friend and others whom you have identified as being involved with your care. If family members or friends are present while care is being provided, we will assume you are comfortable with your companions hearing the discussion, unless you state otherwise. In a disaster situation, we also may disclose relevant protected health information to disaster relief organizations to help locate your family members or friends or to inform them of your location, condition or death.

We may use or disclose medical information about you for **fundraising** efforts in support of our organization, unless you tell us otherwise. We also may contact you for **appointment reminders** or to tell you about or recommend **possible treatment options and other health-related benefits, classes or services** that may be of interest to you.

Subject to certain requirements, we are **permitted or required by law** to make certain other uses and disclosures of your medical information without your authorization.

For instance, we will release your medical information if we suspect child abuse or neglect, if we believe you to be a **victim of abuse, neglect, or domestic violenc**e, and as required by law to report wounds, injuries and crimes. We may disclose your medical information for **public health purposes** such as reporting births and deaths, and reporting information to prevent and control disease. We may disclose your medical information to a health oversight agency such as the Department of Health and Human Services for **health oversight activities** including, but not limited to, conducting an audit or inspection of our facility. We may also disclose your medical information to **coroners and funeral directors**, as well as to **organ donation agencies** (to facilitate organ and tissue donation and transplantation).

We may disclose medical information about you for **workers' compensation** purposes if you are injured on the job. We may also disclose medical information **when permitted or required by law**, such as in response to a request from **law enforcement officials** in specific circumstances, and in response to valid judicial, administrative, or court orders. We may also disclose information about you in certain **emergencies** or to **avert or lessen a serious threat to the health and safety** of a person or the public. We may release your medical information if you are a member of the military as required by armed forces services, or if necessary for **national security or intelligence activities**. We may also disclose medical information for purposes of medical **research studies** when such use has been approved by an Institutional Review Board.

For Health Information Exchange. We may participate in one or more health information exchanges (HIEs) and may electronically share your health information for treatment, payment and healthcare operations purposes with other participants in the HIEs. HIEs allow your health care providers to efficiently access and use your pertinent medical information necessary for treatment and other lawful purposes. For example, we may participate in quality improvement projects with the Greater Cincinnati Health Council, HealthBridge, Inc. and/or the Health Improvement Collaborative of Greater Cincinnati in an effort to improve care and treatment related to certain diseases such as adult diabetes and pediatric asthma. If you do not opt-out of this exchange of information, we may provide your health information to the HIEs in which we participate in accordance with applicable law.

Other uses of medical information. Most uses and disclosures of psychotherapy notes (where appropriate), uses and disclosures of protected health information for marketing purposes, and disclosures that constitute a sale of protected health information require your written authorization. In any other situation not covered by this notice, we must receive your written authorization before using or disclosing your medical information. If you choose to authorize use or disclosure, you have the right to later revoke that authorization by notifying us in writing of your decision.

Your rights regarding your medical information.
In most cases, **you have the right to receive a copy and/or inspect the medical information** we retain about you, upon written request. After the first request for copies, we may charge a fee for the cost of copying, mailing or other related supplies. If we deny your request, you may submit a written request for a review of that decision. In some circumstances, another licensed health care professional chosen by St. Elizabeth Physicians may review your request and denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review. However, in some circumstances, our denial of a request by you to inspect and/or receive copies of your information is not subject to review.

You have the right to request that we amend your medical information, by submitting a request in writing that provides your reason for requesting the amendment. We have the right to deny your request if the information was not created by us, if it is not part of the medical information maintained by us, if it is not part of the information which you would be permitted to inspect and copy, or if in our opinion that record is accurate. If we deny your request, we will provide you with a written statement of the basis for the denial and a description of how you may file a written statement of disagreement. If you do not file a written statement of disagreement, you may request that your request for amendment and our written denial be provided with any future disclosures of your medical information.

You have the right to a list of those instances where we have disclosed your medical information when you submit a written request. This list will not include: disclosures made for treatment, payment or health care operations; disclosures made directly to you; disclosures you authorized pursuant to a signed authorization; disclosures for facility directory purposes or to persons involved in your care; and disclosures made to correctional institutions and for other law enforcement purposes. The request must state the time period desired for the accounting, which must be less than a 6-year period and start after April 14, 2003. You may receive the list in paper or electronic form. The first disclosure list request in a 12-month period is free. Additional requests may be provided for a fee. We will inform you of the fees before you incur any costs.

You also have the right to be notified if there is a breach of your unsecured protected health information.

If this notice was sent to you electronically, **you have the right** t**o a paper copy of this notice.**

You have the right to request that medical information about you be communicated to you in a confidential manner, such as sending mail to a P.O. Box instead of your home address, by notifying us in writing of the specific way or location for us to use to communicate with you. We will not ask you the reason for your request. We will accommodate all reasonable requests, but we may not be able to agree to your request.

You may request, in writing, that we not use or disclose medical information about you for treatment, payment or healthcare operations or to persons involved in your care except when specifically authorized by you, when required by law, or in an emergency. You are entitled to a restriction to not disclose information to your health plan for health care services that we provided for which you paid us directly in full when the purpose of the disclosure is for the health plan's payment or health care operations. We are not required to agree to other types of requests. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

All written requests or appeals should be submitted to:
Corporate Privacy Officer
St. Elizabeth Physicians
334 Thomas More Parkway. Suite 200
Crestview Hills, KY 41017

Complaints

If you are concerned that your privacy rights may have been violated, or if you disagree with a decision we made about access to your records, you may lodge a written complaint with our Corporate Privacy Officer in writing. Finally, you may send a written complaint to the U.S. Department of Health and Human Services Office for Civil Rights. Our Corporate Privacy Officer can provide you with the address. Under no circumstance will you be penalized or retaliated against for filing a complaint.

Privacy Officer

If you have questions or need further assistance regarding this Notice, please contact the Corporate Privacy Officer at St. Elizabeth Physicians, 334 Thomas More Parkway. Suite 200, Crestview Hills, KY 41017 (866)-669-5124 or by Fax line (859) 344-5553

St. Elizabeth PHYSICIANS

Receipt of Notice of Privacy Practices
ALTERNATE COMMUNICATION REQUEST FORM

Patient Name _____ Date of Birth _____/_____/_____
(Print full name)

I wish to be contacted in the following manner (check all that apply):

☐ By home, cell or work phone listed in my registration as below.

Home	Cell	Work		Other
☐	☐	☐	O.K. to leave message on voice mail	_____
☐	☐	☐	O.K. to leave message with individual	_____
☐	☐	☐	Leave message with call-back number only	_____
☐	☐	☐	Do not leave message	_____

☐ Written Communication

- ☐ O.K. to mail to my home address
- ☐ O.K. to mail to my work/office address
- ☐ O.K. to mail text me
- ☐ O.K. to fax to this number _____
- ☐ O.K. to e-mail to address listed in my registration

I, _____ give permission to the following individuals to obtain the indicated information:
(Name of Patient or Responsible Party)

_____ whose relation to me is _____Phone (____)_____-_____
(Name of person) (Relationship to Patient)

_____ whose relation to me is _____Phone (____)_____-_____
(Name of person) (Relationship to Patient)

_____ whose relation to me is _____Phone (____)_____-_____
(Name of person) (Relationship to Patient)

_____ whose relation to me is _____Phone (____)_____-_____
(Name of person) (Relationship to Patient)

_____ Prescription refills on my behalf
_____ Test results on my behalf
_____ Set up appointment/ or cancel on my behalf
_____ Speak to the doctor/MA either in person or by telephone on my behalf
_____ Pick up prescriptions, doctor's orders, or other needs on my behalf with a photo ID.

Effective Date _____Expires _____Revoked _____

_____ ***Please note:*** ***This form does not apply to pregnancy, sexually transmitted diseases, contraception, chemical dependency/substance abuse, or psychiatric/psychological conditions.***
Initials

It is the responsibility of the patient to notify the physician's office if there is a change in this information.
*****Scan original in chart, copy may be given to patient*****

By signing this waiver I release St. Elizabeth Physicians and its staff therein, from any liability for release of information pertaining to my medical care as designated above and I acknowledge that I have received a copy of St. Elizabeth Physicians ***Notice of Privacy Practices****. The effective date of the notice is*: 09/23/13

Signature of patient or responsible person _____

Relationship of Representative to Patient _____ Date _____

Signature of witness _____Date _____

St. Elizabeth PHYSICIANS

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION ST. ELIZABETH PHYSICIANS

Pt. MRN _____

HealthPort Office # _____

_____ _____ _____ _____

Printed Name of Patient Patient's Social Security Number Date of Birth Today's Date

Address _____

Street Address City State Zip Code Phone

X _____ _____ _____

Signature of Patient or Patient's Representative Relationship of Representative to Patient Expiration Date or 90 days

X _____

Signature of Witness

MUST HAVE COMPLETE INFORMATION BEFORE THIS REQUEST CAN BE PROCESSED.

I hereby authorize the use and disclosure (release) of my Medical Record information:

From: To:

_____ _____

_____ _____

_____ _____

The information to be released includes: ___ Entire Medical Record ____ Other _____

_____

The Medical Record Information will be used and/or disclosed for the following purposes:

☐ At the request of the individual ☐ Changing Primary Care Physician ☐ Changing/seeing Specialist
☐ Other (write purpose here) _____

_____

I acknowledge and agree that the term Medical Record information may include: notes by the provider and other personnel, results, reports, correspondence, x-rays and other diagnostic imaging films, as well as claims, billing, and payment information. I expressly authorize the use and/or disclosure of information concerning HIV testing or treatment of AIDS or AIDS-related conditions, any drug or alcohol abuse, drug related conditions, alcoholism, and/or psychiatric/psychological conditions unless specifically excluded.

Please <u>exclude</u> the following information, if it is part of my Medical Record information (*Check any or all you want **excluded** from this authorization for use or disclosure*):

☐ Chemical Dependency/Substance Abuse ☐ Psychiatric/psychological conditions
☐ Sexually Transmitted Diseases ☐ Alcohol ☐ Drugs ☐ N/A

I understand that this Authorization shall remain in effect for a period of **<u>90 days</u>**. I further understand that I may revoke this Authorization at any time by notifying St. Elizabeth Physicians in writing. However, if I choose to do so, I understand that my revocation will not affect any actions taken by St. Elizabeth Physicians before receiving my revocation.

I understand that I have the right to restrict disclosure of my PHI to a health plan, if the disclosure is for payment or healthcare operations and pertains to a healthcare item or service for which I have paid out-of-pocket in full. I have the right to an accounting of disclosures of any and all breach notifications of my unsecured PHI upon my written request to the SEP Privacy Officer. I also understand I have the option to "opt-out" of receiving communications from my provider should I choose to do so as long as I provide them with the request in writing.

A PHOTO IDENTIFICATION WILL BE REQUIRED TO PICK UP MEDICAL RECORDS

_____ I am designating _____to pick up my medical record. I understand my designee or I will need to produce a picture I.D. in order to obtain the records.

Refusal to sign this authorization in no way affects my treatment, payment, or eligibility for benefits. Any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules.

Patient received free copy YES NO, dates included to Chart in MZ Storage YES NO
Return chart to: MZ Storage Office Box # Chart # _____