



Patient Registration / Consent to Treat / Notice of Privacy Practices

Please print the information below and have your insurance card and driver's license or legal photo ID available.

PATIENT INFORMATION

Last Name First Name Middle

Preferred Name

Address City St Zip

Mobile Phone Home Phone Email:

Interpreter Needed: Y N Preferred Language:

May we leave detailed messages that would include protected health information... on your voicemail? Y N

Social Security # Date of Birth Legal Sex

Race (check one): Ethnicity Marital Status Gender Identity: Preferred Pronoun

Emergency Contact (Name) (Relationship) Phone

Does the Patient have a Healthcare Power of Attorney, Advanced Directive, or Guardianship Order? Y N

Has St. Elizabeth Physicians received a copy? Y N

Pharmacy Most Used by Patient Pharm. Phone

Referring Provider (Specialist office only)

Patient Employer Emp. Address Emp. Phone

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

Relationship to Patient: Self Parent Spouse Other

Social Security # Name

Address City St Zip

Primary Phone Alternate Phone Email:

Date of Birth Legal Sex Employer

INSURANCE INFORMATION (Provide card at front desk)

PRIMARY INSURANCE COMPANY NAME No Insurance (Circle if applicable)

Subscriber Relationship to Patient: Self Parent Spouse Other

Subscriber Name: Date of Birth

NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the St. Elizabeth Physicians Notice of Privacy Practices. The effective date of the Notice of Privacy Practices is September 23, 2013.

CONSENT TO TREAT

I consent to examination, diagnosis, and general medical care and treatment (including, but not limited to, physical examination, administration of medications and vaccinations, recordings, and photographs for diagnosis and/or treatment, diagnostic tests, laboratory tests, and other minor procedures) to be performed by my physician, advanced practice provider, and any other associates of St. Elizabeth Physicians. 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 to 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 access by St. Elizabeth Physicians of my medical information for treatment by St. Elizabeth Physicians and release of medical information to any and all providers involved in my care. I permit a copy of this authorization to be used in 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 pre-certifications or referral needed for my insurance. According to recognized coding rules, you may receive separate charges for procedures, physicians, and other problems during a single visit. I understand that St. Elizabeth Physicians will use your protected health information, as necessary, for your treatment, to obtain payment for treatment, and for the healthcare operations of St. Elizabeth Physicians.

I consent to receive communications at the phone numbers and address identified above. These communications may include, but are not limited to, live or prerecorded voices or text messages, letters, and may come from St. Elizabeth Physicians, its affiliates, its associates, business associates, or other third parties acting on St. Elizabeth Physicians behalf. Message and data rates may apply.

I further authorize the access of my clinical and medication information for treatment by St. Elizabeth Physicians and to any and all providers directly involved in my care.

Signature X _____
(Signature of patient or patient representative)

Date _____

Witness _____

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 violence**, 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 to 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



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

INVOLVEMENT IN CARE

I agree that St. Elizabeth Physicians, including any central service department of St. Elizabeth Physicians, may disclose my health information* at any time to the following individuals who are involved in my care:

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

I acknowledge that the individuals identified above are involved in my healthcare or its payment. Health information* includes test results, prescription refill information, appointment scheduling and cancellation, and billing information. Information regarding substance use disorder treatment, psychiatric or psychological conditions and treatment, pregnancy, contraception, sexually transmitted disease test results and treatment are **not** included. I understand that this consent can be revoked at any time by contacting St. Elizabeth Physicians. I also understand that nothing in this consent is intended to limit or alter St. Elizabeth Physicians ability to disclose health information to individuals not listed on this form in accordance with applicable law.

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

Witness _____



AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Pt. MRN _____

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

Street Address _____ City _____ State _____ Zip Code _____ Phone _____

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

MUST HAVE COMPLETE INFORMATION BEFORE THIS REQUEST CAN BE PROCESSED.

I hereby authorize the use and disclosure of my Protected Health Information:

	Release Information From:	Release Information To: (Required)
Name		
Address		
City, State, Zip		
Phone		
Fax		

The information to be released includes:

- Entire Chart: Last 2 years of active treatment will be provided unless specified. Dates _____
- Specific Department/office only (Behavioral Health, Women's Health, etc.) _____
- Other information requested, please specify: _____

The Protected Health Information will be used and/or disclosed for the following purposes:

- At the request of the individual Changing Physician Seeing a Specialist
- Other (write purpose here) _____

I acknowledge and agree that the term protected health information may include: notes by my 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 and substance abuse treatment information, drug related conditions, alcoholism, and/or psychiatric/psychological conditions.

I understand that this Authorization shall remain in effect for a period of **90 days**. 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.

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. I understand that if substance use disorder treatment information is disclosed pursuant to this Authorization, it is not subject to redisclosure by the recipient without my express written consent unless otherwise permitted by Federal regulations governing Confidentiality and Substance Use Disorder Patient Records, 42 C.F.R. Part 2, or the Health Insurance Portability and Accountability Act of 1996, C.F.R. Parts 160 & 164.

A PHOTO IDENTIFICATION WILL BE REQUIRED TO PICK UP MEDICAL RECORDS

I understand my designee or I will need to produce a picture I.D. in order to obtain the records

Patient Financial Expectations

Thank you for choosing St. Elizabeth Physicians as your preferred provider. We are committed to providing our patients with comprehensive and compassionate care that improves the health of the community we serve. This communication was developed to provide detailed information regarding patient insurance and financial responsibility for services rendered.

1. **Insurance** – St. Elizabeth Physicians (SEP) participates with most insurance plans, including Medicare. Please use the website at www.stedocs.com when searching for a provider or a participating insurance carrier.
2. **Proof of insurance** – All patients are responsible for providing the correct insurance information at each visit. The patient service representative at the office will scan and store a copy of the most current insurance card. If the patient is not insured by a plan SEP participates with, the charges for the visit may be denied and become the patient's responsibility. If the patient is insured by a participating plan but does not have an up-to-date insurance card, SEP will attempt to verify coverage. If unable to do so, the balance may become the patient's responsibility.
3. **Insurance coverage changes** – If there is a change in insurance, the patient is responsible for notifying the patient service representative upon arrival at the office. Failure to provide the correct insurance information within 30 days of the visit may result in the total balance becoming patient responsibility. At any point, changes in insurance may also be submitted to SEP by calling (859) 344-5555 or by sending a message through the online patient portal, MyChart.
4. **Co-payments** – All co-payments are due at the time of service. This arrangement is a contractual obligation with the patient and their insurance company. SEP accepts cash, check, Visa, MasterCard, Discover and American Express.
5. **Outstanding balances** – Patients with an outstanding balance will be notified of such balance at the time of appointment scheduling, arrival of the appointment as well as checking out after the appointment. If unable to pay the balance in full, a payment plan can be arranged with the patient service representative or the Central Billing Office by calling (859) 344-5555.
6. **Appointment scheduling** – Patients with an outstanding balance will be requested to make a payment at the time of scheduling an appointment. If the patient cannot make the required payment, they will be asked to set up a payment plan before the appointment will be scheduled. After the payment plan has been arranged, the patient will be eligible to schedule their appointment.
7. **Financial Assistance** – Financial assistance is available to all patients based on need. The patient service representative at the office can provide the necessary paperwork or it can be downloaded from the website at www.stedocs.com by clicking on Resources, Financial Assistance Programs.

8. **Non-covered services** – Not all services received may be covered by insurance. The provider's office will attempt to determine if a procedure will be covered or not. If a service is deemed to be "non-covered", the patient will be notified. The charge for the service and amount owed by the patient will be explained prior to receiving the service. The patient must approve the service and acknowledge the amount owed before the service will be rendered. Payment will be due after the insurance has processed the claim and upon receipt of your statement. If unable to pay the balance in full, the patient may set up a payment plan by calling the Central Billing Office at (859) 344-5555.
9. **Payment plan arrangements** – SEP may approve a monthly payment plan arrangement if special circumstances prevent the patient from making full payment. Payment plans may be arranged by patient service representatives in the SEP offices or by Central Billing Office (CBO) associates. CBO associates are available Monday through Thursday from 8:00 a.m. to 5:30 p.m. and Friday 8:00 a.m. to 4:00 p.m. They can be reached by calling (859) 344-5555 or toll free at (877) 687-3303. Inquiries can also be made through the online patient portal, MyChart. Failure to meet the agreed arrangement of the payment plan may result in the patient's account being referred to a third party collection agency.
10. **Claims submission** – SEP will bill all applicable insurances and assist in any way reasonable to help get the claims paid. If the claim is denied, SEP will follow up with the payor and appeal the denial, if appropriate. If the appeal is overturned, the balance may become the patient's responsibility. At times, the insurance company may request certain information directly from the patient, it is the responsibility of the patient to comply with their request. If the information needed is not supplied, the balance could become the patient's responsibility.
11. **Statements** – Statements will be mailed to the patient's address on file once the balance has been deemed to be the patient's responsibility. Statements under \$10 are not mailed but the amount due may be requested from an SEP patient service representative at any point.
12. **ECA (Extraordinary Collection Activities)** – Statements are mailed to the patient monthly. If the account is over 90 days past due, the status of Final Notice will appear on the billing statement. The outstanding amount will be due in 10 days. Partial payments will not be accepted unless otherwise negotiated. If a balance remains unpaid, SEP may refer the account to a third party collection agency. Accounts will not be referred to an agency when the insurance denied payment due to an error by SEP nor will the patient be referred to a collection agency while their Financial Hardship application is in process.

Thank you for your understanding and adherence to the SEP patient financial responsibility expectations. If you have any questions or concerns, our associates are here to help. Please contact us at (859) 344-5555.