EAST MONTGOMERY PRIMARY MEDICINE

❑ **470 Taylor Road, Suite 310**
Montgomery, AL 36117

❑ **4250 Carmichael Court North**
Montgomery, AL 36106
Phone: 334-747-4322 Fax: 334-747-4321
Website:
http://www.baptistfirst.org/east-montgomery-primary-medicine

To Our Patient
It is our goal to provide efficient and effective health care in a clean well organized facility, which places our patients' needs first. We look forward to building a warm, dependable, and lasting relationship with you and your family. Please take the time to review our website, we have various forms and documents that you might want to take advantage of.

Services Offered
A Primary Care Physician must possess knowledge in medical care that includes internal medicine, gynecology, minor surgical and dermatological procedures, preventive health care, and geriatrics. We will see patients of all ages starting at age 18. It is our goal to pursue current medical training and give each patient the best comprehensive medical care.

Some Specific Medical Services and Procedures Routinely Offered Include:

- Physical Exams / Check-ups
- Acute/Chronic Medical Problems
- Immunizations
- Women's Health / GYN Exams
- Radiology and Laboratory Services
- Age specific screening
- Emergency care of injuries and illness
- Sick visit appointments
- Minor Surgery (In-office)
- Wound Care
- Joint Injections
- Patient Education

Office Hours and Appointments
Office hours are 8:00 a.m. to 4:30 p.m. Monday through Thursday and Friday 8:00 a.m. to 12:00 p.m. All patients are seen by appointment; same day/next day appointments are available.

If you are a *new patient* to our office, we ask that you arrive 30 minutes prior to your appointment time. Please bring your photo ID, insurance cards, and any medications you may be taking to your appointment.

Patients that are more than 20 minutes late to their appointment time may be asked to reschedule or you will be placed into a later appointment slot for the day. We ask that you respect the time of other patients as well as the providers by arriving on time.

After Hours, Weekends, and Holidays
For NON-URGENT problems (test results, prescription refills) please call the office during business hours. If you have an URGENT problem and need to speak to your physician when the office is closed, call 334-277-8330 to reach the hospital operator and they will reach the physician on call.
Please reserve all after hours calls for situations that require your provider's immediate attention but is NOT an emergency.

If It Is An EMERGENCY Go Directly To The Emergency Room or Call 911!(ex. Loss of limb, eyesight, chest pains, shortness of breath, stroke)

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Our Patient Portal
Please sign up for our patient portal. Signing up is simple. Provide us with your updated email address the day of your next scheduled appointment and at mid-night that night you will received an email link to sign up. You can send messages to us, request refills and receive test results and much more. For questions or concerns regarding the patient portal call **1-877-621-8014**.

Telephone
Our goal is to efficiently route your call to the appropriate staff member. We have a very simple menu to help get you to the right staff member. If you select an option and receive a voicemail please be sure to leave a message with your name, DOB and reason for the call – so that the staff can return the call when they return to their desk. We will do our best to return non-urgent calls in 24 to 48 hours. If you have an urgent need your call will be tended to as soon as possible, but if it is life threating please call 911.

Follow Up Appointments
It is important that you keep follow up appointments as directed by your provider. Please be sure to bring an updated list of medications (dosage amount, frequency) including over the counter medications, vitamins and supplements. If you do not have a list you may bring your medicine bottles. This will allow us to have a more accurate list of what medications you are currently taking.

Medication Refills
We ask that you request refills for medications ***during*** your office visit, if you forget…please call your pharmacists to do so and advise them to send the request electronically. *We do not accept faxed refill requests.* If the provider prescribes a narcotic for a period of time, you will be asked to sign a controlled substance contract. Refills for narcotics should be requested at your pharmacy and sent electronically, however depending on the medication you may be asked to pick up the signed written prescription when ready at our office. We will call you when ready, otherwise check with your pharmacy in 24-48hrs of your request. We are allowed by the State of Alabama to call certain narcotics in (scheduled III, IV, V meds) – all others must be picked up. Any refills picked up in the office will require you to show a photo ID and sign our prescription log. On call providers do not refill narcotics after hours.

If your insurance company requires a *prior authorization* approval for a medication – please allow an additional 48-72 for processing.

New Medication Requests
If you need an antibiotic or a new medication that we have not prescribed in our office – please choose the option for the *office nurse* advising her of your new medication request. You will likely need an appointment in order to process your request.

Test Results
You can expect to be notified of you test results from this clinic 4-5 days after your testing has been completed. If your tests results are significantly abnormal you will be notified by phone ASAP. You will be notified of your results by our patients portal (if you signed up), a telephone call or via US mail.

Form Requests
We charge a $15 or $25 fee for completion of forms. We have a 7-10 day turn-around. The fee depends on the length of the document.

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No Shows
It is important that you keep your appointment to provide the best care possible, if you are unable to make your appointment please be sure to call our office at least 24hr prior to cancel your appointment. No shows cause a disruption in the provider's schedule and are considered non-compliant with your care. Not showing up for an appointment can result in dismissal. You may be considered for dismissal if you incur any combination of No shows and/or late cancellations that total three.

Late Cancellations
We ask that you cancel you appointment greater than 24hrs of your scheduled appointment.
This will allow us to backfill slots with sick visits for those who really need to come in. A late cancellation is considered – any cancellation that occurs less than 24hrs (business days) of your scheduled appointment date and time. Late cancellations are counted as an occurrence and you may be considered for dismissal if you incur any combination of late cancellations and No shows that total three.

Insurance
Please call your insurance company to let them know you are now seeing us as a patient. In most cases they will send an updated card with the new PCP provider's name.
You are responsible for assuring that we are on your insurance plan's list of participating providers.
We will make every effort to help go over your benefits but it is ultimately up to the patient to know what benefits they have. Please make sure that you have necessary referrals or pre-certifications for specialists and procedures scheduled on your behalf. If this is not done prior to procedure or visit, the insurance company may refuse to pay claims that you will be held responsible for.

Payment Policy
Payment for patient portion of the visit (co-pays, deductibles, etc.) is expected at the time service is rendered. We accept cash, check, cashier's checks, MasterCard, VISA, American Express and Discover. There will be a $30.00 returned check charge. All outstanding balances will be collected up front prior to seeing the physician. Your cooperation with this policy of payment is appreciated. We do not bill for copays or coinsurance it must be collected at time of service. We do not accept postdated checks, cashier's checks or Starter Checks. *Please bring exact change for copays. Unfortunately due to limited onsite funds we do not accept anything bills larger than $20.* If you have any billing questions please contact our Physician billing office 334-273-4170.

Note from our Practice Manager
Thank you for selecting our office to serve you and your family's healthcare needs. If a situation arises and you need to reach me please feel free to contact me at the above number any time.

Pamela Tuck, M.D.
Carmelita G. Prieto-DeJesus, M.D
Louisa M. Tolentino, M.D.
Pooja Ummalaneni, M.D.
Jessica Rollins, C.R.N.P.
Rebecca Buckalew, C.R.N.P.
Wendy Castillo, C.R.N.P.
Amanda Breshears, Practice Manager

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New Patient Packet Instructions

Thank you for choosing us for your primary care needs. Included in the new patient pack:

- **Welcome Letter**, which is a copy for you to keep. It explains the policies and procedures for our office as well as general information about the practice.
- **New Patient History** (front/back): The patient will need to fill out and bring to the appointment. We ask that you provide as much information as possible so that we can provide quality healthcare to you.
- **Disclosure of Protected Health Information**: This form designates who you want to have access to your medical information, please fill out and bring to your appointment, and this form can be updated in the future if anything changes.
- **Notice of Privacy Practices Acknowledgment of Receipt**: Included in your packet is our Notice of Privacy Practices; it is your copy to keep and explains how your medical information may be used. After you have read the policy please print, sign, and date on the Notice of Privacy Practices Acknowledgment of Receipt and bring with you to you appointment.
- **Medical Records Release**: If you have records at another Primary healthcare provider's office we have enclosed a release form. We prefer to have these records on your appointment date, so please submit the request to your Primary Care Provider ASAP. Thank you.
- **Map**: we have provided a map of the Baptist East Hospital Campus to help you find our office along with a picture of the building we are located in.
- As a new patient we ask that you arrive 30 minutes prior to your appointment time to register. As well as bring you insurance card, photo ID, copay, and any medications you may currently be taking.

If you have any questions or concerns, please feel free to contact us at 334.244.4322.

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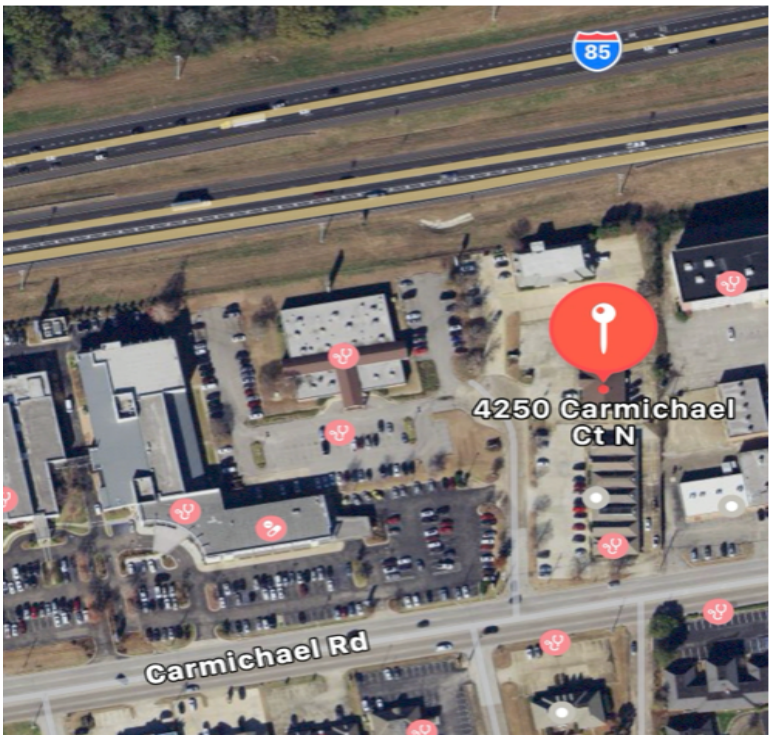

BAPTIST HEALTH PHYSICIAN GROUP

NEW PATIENT HISTORY FORM

Name: _____ **Date of Birth**_____

What brings you into the office today?_____

_____

Medical History: Please check any of the following medical conditions that apply to you or your family.

	Yourself	Father	Mother	Children	Siblings	Grandmother	Grandfather
Alcoholism	☐	☐	☐	☐	☐	☐	☐
Allergies	☐	☐	☐	☐	☐	☐	☐
Anemia	☐	☐	☐	☐	☐	☐	☐
Aneurysm	☐	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐	☐
Bleeding Disorder	☐	☐	☐	☐	☐	☐	☐
Blood Clot (where?)_____	☐	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐	☐
Congestive Heart Failure	☐	☐	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐
Diverticulosis	☐	☐	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐	☐	☐
Emphysema / COPD	☐	☐	☐	☐	☐	☐	☐
Epilepsy / Seizures	☐	☐	☐	☐	☐	☐	☐
Fibromyalgia	☐	☐	☐	☐	☐	☐	☐
GERD / Acid Reflux	☐	☐	☐	☐	☐	☐	☐
Heart Disease/Heart Attack	☐	☐	☐	☐	☐	☐	☐
Heart Arrhythmia	☐	☐	☐	☐	☐	☐	☐
Hepatitis / Liver Disease	☐	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐	☐	☐	☐
Kidney Stones	☐	☐	☐	☐	☐	☐	☐
Migraine	☐	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐	☐
Prostate Enlargement	☐	☐	☐	☐	☐	☐	☐
Psychiatric Problems	☐	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐	☐
Tuberculosis	☐	☐	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐	☐	☐
Sickle Cell Disease	☐	☐	☐	☐	☐	☐	☐
Sleep Apnea	☐	☐	☐	☐	☐	☐	☐

SURGICAL HISTORY (TYPE AND DATE):

1. _____ 4. _____ 7._____
2. _____ 5. _____ 8._____
3. _____ 6. _____ 9._____

CURRENT MEDICATIONS: Please include any vitamins, herbs, and over the counter medications you are taking.

1. _____ 4. _____ 7._____
2. _____ 5. _____ 8._____
3. _____ 6. _____ 9._____

HOSPITALIZATIONS: Please note where, for what and when.

1. _____ 3. _____ 5._____
2. _____ 4. _____ 6._____

ALLERGIES: Please list any medications, food or chemicals that cause your allergies.

1. _____ 3. _____ 5._____

2. _____ 4. _____ 6._____

SOCIAL HISTORY: Please check all that apply to you. Note how much per day and for how long when appropriate.

❑ Current / Past Alcohol use _____
❑ Chew Tobacco _____
❑ Current / Past Drug use _____
❑ Regular Exercise _____
❑ Single ❑ Married _____
❑ Separated ❑ Widowed _____
❑ Divorced _____
❑ Current / Past Smoking _____
❑ Caffeine _____

Previous Sexually Transmitted Disease ❑ _____
Sexually Active ❑ Yes ❑ No
Children ❑ Yes ❑ No How Many?_____
Occupation _____
Religion_____

GYNECOLOGIC HISTORY: Please complete if you are a female.

Number of pregnancies _____
Number of living children _____
Number of miscarriages _____
Number of abortions _____

Date of last Menstrual period ____/_____/____
Age at first period ____/_____/____
Regular periods every month? ❑ Yes ❑ No
Heavy or Painful periods? ❑ Yes ❑ No

Complications during any of your pregnancies (e.g., high blood pressure, diabetes, etc. _____

SYMPTOM REVIEW: Check any symptoms that apply to you. If this is a chronic problem, note how long it has been on going.

GENERAL
❑ Fever / chills
❑ Weight gain / loss
❑ Fatigue
❑ Poor appetite
❑ Hot flashes

ENT/EYES
❑ Headaches
❑ Difficulty hearing
❑ Difficulty seeing
❑ Sinus trouble
❑ Sneezing / Watery-eyes
❑ Nose bleeding

CARDIOVASCULAR
❑ Chest pains
❑ Shortness of breath
❑ Rapid or skipped heart beats
❑ Ankle swelling
❑ Leg pain with walking

URINARY
❑ Blood in urine
❑ Painful urination
❑ Frequent urination
❑ Night time urination
❑ Urinary incontinence

ALLERGY
❑ Asthma
❑ Seasonal Allergies
❑ Immunodeficiency

GASTROINTESTINAL
❑ Stomach pains
❑ Heart burn
❑ Constipation
❑ Black or bloody stool

PULMONARY
❑ Chronic cough
❑ Coughing blood
❑ Wheezing
❑ Shortness of breath

NEUROLOGIC
❑ Numbness / tingling
❑ Weakness
❑ Dizziness
❑ Tremors

MUSCULOSKELETAL
❑ Back pains
❑ Joint pains
❑ Muscle pain

ENDOCRINE
❑ Skin/Hair changes
❑ Thirsty a lot
❑ Always hot

SKIN
New or Changing Moles ❑ Yes ❑ No
Spot/Rashes that won't go away ❑ Yes ❑ No

HEMATOLOGIC
❑ Easy Bruising
❑ Anemia
❑ Sickle Cell

PSYCHOLOGICAL
❑ Depression
❑ Anxiety

IMMUNIZATION AND PREVENTION

Sigmoidoscopy _____/_____
Colonoscopy _____/_____
Mammogram _____/_____
Pap test _____/_____
Rectal Exam _____/_____

Pneumonia Shot _____/_____
Flu Shot _____/_____
Tetanus _____/_____
Hepatitis B shots _____/_____
Stool test/blood _____/_____
PSA test _____/_____

Cholesterol Test _____/_____
Diabetes Test _____/_____
TB skin Test _____/_____
Thyroid Test _____/_____
Bone Density _____/_____

OTHER

Do you have a living will or advance directive for health care? ❑ Yes ❑ No
Do you have a durable power of attorney for health care? ❑ Yes ❑ No

Baptist HEALTH

Ambulatory
Disclosure of Protected Health Information

While receiving medical treatment/services, Baptist Health may release my medical/health information to: (Check all that apply and specify below).

Please note that a new form must be completed in order to make any changes to the list of individuals authorized to receive information related to your health.

____None _____Spouse _____Family member(s) _____Other relative(s)

____Close personal friend(s) _____Personal representative identified by me

If you have marked any of the above, please identify by name below:

SPOUSE: _____

_____

FAMILY MEMBER(S): _____

_____

CLOSE PERSONAL FRIEND(S): _____

_____

PERSONAL REPRESENTATIVE: _____

_____

OTHER RELATIVE(S): _____

_____

_____ _____ _____

Patient and/or Patient Representative Signature Date Time

Print Name: _____

Baptist HEALTH

NOTICE OF PRIVACY PRACTICES

NOTICE OF PRIVACY PRACTICES OF THE HEALTH CARE AUTHORITY FOR BAPTIST HEALTH, AN AFFILIATE OF UAB HEALTH SYSTEM

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.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) directs health care providers, payers, and other health care entities to develop policies and procedures to ensure the security, integrity, privacy, and authenticity of health information, and to safeguard access to and disclosure of health information. As a health care provider, Baptist Health uses your confidential health information to create records regarding that health information in order to provide you with quality care and to comply with certain legal requirements. Baptist Health is committed to maintaining your privacy rights under both federal and state law. This Notice of Privacy Practices applies to records of your care created and/or maintained by Baptist Health.

WHO WILL FOLLOW THIS NOTICE

BAPTIST HEALTH. This Notice describes the privacy practices of the Health Care Authority of Baptist Health, an affiliate of UAB Health System, and all d/b/a's of the Health Care Authority and all affiliated corporations and their d/b/a's.

MEDICAL STAFF MEMBERS. This Notice also describes the privacy practices of an "Organized Health Care Arrangement" or "OHCA" between Baptist Health and eligible providers on its medical staff and their responsibilities of sharing patient information necessary to carry out treatment, payment, and health care operations. Baptist Health providers and other eligible providers have entered into the OHCA under which Baptist Health providers and other eligible providers will:

- Use this Notice as a joint Notice of Privacy Practices for all inpatient and outpatient provisions of medical care and follow all information practices described in this notice;
- Obtain a single signed acknowledgement of receipt;
- Notify you in the case of a breach of your identifiable medial information; and
- Share medical information from inpatient and outpatient provisions of medical care with eligible providers so that they can help Baptist Health with its health care operations.

The OHCA does not cover the information practices of practitioners in their private offices or at other practice locations.

Because Baptist Health is a clinically−integrated care setting, our patients receive care from Baptist Health staff and from independent practitioners on the medical staff. Baptist Health and its medical staff must be able to share your medical information freely for treatment, payment, and health care operations as described in this Notice. Although all independent medical staff members who provide care at Baptist Health follow the privacy practices described in this Notice, they exercise their own independent medical judgment in caring for patients and they are solely responsible for their own compliance with privacy laws. Baptist Health and independent medical staff members remain completely separate and independent entities that are legally responsible for their own actions.

HEALTH INFORMATION EXCHANGE/HEALTH INFORMATION ORGANIZATION (HIE/HIO). HIEs/HIOs allow health care providers, including Baptist Health, to electronically share and receive information about patients, which assists in the coordination of patient care. Baptist Health participates in an HIE/HIO ("Patient Bridge") that may make your health information available to other providers, health plans and health care clearinghouses for treatment and/or payment purposes. Your health information may be included in the HIE/HIO. Baptist Health may also make your health information available to other HIE/HIO participants that request your information for coordination of your treatment and/or payment for services rendered to you. You may choose **NOT** to have your health information included in the HIE/HIO by completing the Participation Change Request Form. A copy of the Participation Change Request Form may be found at http://www.baptistfirst.org/patient−bridge. Completing the Participation Change Request Form will not affect your ability to receive health care.

USES AND DISCLOSURES OF INFORMATION WITHOUT YOUR AUTHORIZATION

The following categories describe different ways we may disclose your medical information without your permission. Where state or federal law restricts one of the described uses or disclosures, we follow the requirements of such state or federal law. These are general descriptions only. Although we cannot list every disclosure or use within a category, we are only permitted to use or disclose your health information without your authorization if it falls within one of these categories below. If your health information contains information regarding your mental health or substance abuse treatment or certain infectious diseases (including HIV/AIDS tests or results), we are required by state and federal confidentiality laws to obtain your consent prior to certain disclosures of the information. Once we have obtained your consent, we will treat the disclosure of such information in accordance with our privacy practices outlined in this Notice.

Treatment. We may use and disclose your medical information for treatment and/or services. We may disclose medical information about you with our nurses, your physicians, or other Baptist Health personnel who are involved in your care at Baptist Health. Different departments within Baptist Health may need to share information about you in order to coordinate the different aspects of your care; for example, prescriptions, lab work, and X−rays. Further, we may disclose any information relating to your health to any non−Baptist Health physician(s), health care providers, and/or health care facilities for the sole purpose of providing current and/or future medical care. Baptist Health may use and disclose your medical information to inform you and/or to recommend to you possible treatment options and/or available alternatives that may be of interest to you and your health.

Payment. We may use and disclose your medical information so that treatment and/or services you received

through Baptist Health may be billed to and payment may be collected from you, an insurance company, or other third party. Further, we may also inform your health insurance plan about a treatment or service you plan to receive in order to obtain prior approval or to determine whether your health insurance plan will cover the treatment and/or service. Additionally, we may also disclose medical information about you to other medical care providers, medical plans, and health care clearinghouses for their payment purposes. If state law requires, we will obtain your permission prior to disclosing to other providers or health insurance companies for payment purposes.

Health Care Operations. We may use and disclose your medical information in the course of Baptist Health's routine operations. These disclosures and uses are necessary to the operation of Baptist Health to ensure that all of our patients receive quality care. For instance, we may use the medical information to review our treatment, services, and evaluation of our staff's performance of your care. Such information may be combined with other patient information to determine the value and effectiveness of services provided by Baptist Health. Further, such information may also be disclosed to physicians, nurses, technicians, medical residents, students, and/or other Baptist Health personnel for review and learning purposes. We may also combine the medical information we have with medical information from other entities to compare how we are doing and see where we can make improvements in the care and services we offer our patients.

Business Associates. We may disclose your medical information to our business associates and allow them to create, use, and disclose your medical information to perform their job. For example, we may disclose your medical information to an outside billing company who assists us in billing insurance companies.

Appointment Reminders. We may contact you as a reminder that you have an appointment for treatment or medical services. We may use and disclose your medical information to tell you about benefits and/or services that may be of benefit to your health.

Treatment Alternatives. We may contact you to provide information about treatment alternatives or other health−related benefits and services that may be of interest to you.

Fundraising. We may use your medical information to contact you as part of a fundraising effort. For example, we may disclose certain elements of your medical information, such as your name, address, phone number, and dates you received treatment or services, to a foundation related to Baptist Health so they may contact you to raise money for Baptist Health. You have a right to opt out of fundraising communications. If you do not wish to be contacted regarding fundraising, please contact the Baptist Health Care Foundation at 334−273−4567. Your decision whether or not to receive fundraising communications will not affect your ability to receive health care services at Baptist Health.

Certain Marketing Activities. We may use your medical information to forward promotional gifts of nominal value, to communicate with you about products, services, and educational programs offered by Baptist Health, to communicate with you about case management and care coordination and to communicate with you about treatment alternatives.

Facility Directory. We may include your name, location in the facility, general condition (e.g. fair, stable, etc.), and religious affiliation in a facility directory. This information may be provided to members of the clergy and, except for religious affiliation, to other people who ask for you by name. We will not include your information in the facility directory if you object or if we are prohibited by state or federal law. If you choose not to be listed in the directory, we will not be able to inform your family and/or friends that you are receiving treatment and/or services in our facility.

Family and Friends. We may disclose your location or general condition to a family member or your personal representative. If any of these individuals or others you identify are involved in your care, we may also disclose such information as directly relevant to their involvement. We will only release this information if you agree, are given the opportunity to object and do not, or if in our professional judgment, it would be in your best interest to allow the person to receive the information or act on your behalf. For example, we may allow a family member to pick up your prescriptions, medical supplies, or X−rays. We may also disclose your information to an entity assisting in disaster relief efforts so that your family or an individual responsible for your care may be notified of your location and condition.

Required by Law. We may use and disclose your information as required by the federal, state, or local law.

Public Health Activities. We may disclose medical information about you for public health activities. These activities may include disclosures:

- To a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability;
- To appropriate authorities authorized to receive reports of child abuse and neglect;
- To FDA−regulated entities for purposes of monitoring or reporting the quality, safety, or effectiveness of FDA−regulated products;
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; or
- To any employer if the employer requires the healthcare services to determine whether you suffered a work−related injury.

Abuse, Neglect or Domestic Violence. We may notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence. We are required to report child, elder, and domestic abuse and/or neglect to the State of Alabama. All abuse reports will be made to the appropriate authorities in accordance with federal and state laws.

Health Oversight Activities. We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities may include audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if reasonable efforts have been made to notify you of the request or to obtain an order from the court protecting the information requested.

Law Enforcement. We may release medical information for law enforcement purposes as required by law in response to a valid subpoena; for identification and location of fugitives, witnesses, or missing persons; for suspected victims of crimes; for deaths that may have resulted from criminal conduct; and for suspected crimes on Baptist Health premises. Further, we may release medical information in emergency circumstances

to report a crime; the location of the crime or victims; or the identity, description, and/or location of the person who committed the crime. Information disclosed to law enforcement relating to the victim of a crime may be made if the appropriate consent by the victim has been obtained or under limited circumstances, if the victim's consent cannot be obtained. Any information released to law enforcement will be made in accordance to HIPAA.

Coroners, Medical Examiners, and Funeral Directors. We may release medical information to a coroner, medical examiner, or funeral director as necessary for them to carry out their duties.

Organ, Eye or Tissue Donation. If you are an organ donor, we may release medical information to organ, eye or tissue procurement, transplantation or banking organizations, or entities as necessary to facilitate organ, eye, or tissue donation and transplantation.

Research. Under certain circumstances, we may use or disclose your medical information for research, subject to certain safeguards. For example, we may disclose information to researchers when their research has been approved by a special committee that has reviewed the research proposal and established protocols to ensure the privacy of your medical information. We may disclose medical information about you to people preparing to conduct a research project, but the information will stay on site.

Threats to Health or Safety. Under certain circumstances, we may use or disclose your medical information to avert a serious threat to health and safety if we, in good faith, believe the use or disclosure is necessary to prevent or lessen the threat and is to a person reasonably able to prevent or lessen the threat (including the target) or is necessary for law enforcement authorities to identify or apprehend an individual(s) involved in a crime.

Specialized Government Functions. We may use and disclose your medical information in the following specialized circumstances and/or functions:

- If you are member of the United States military or a veteran of the United States military, we may disclose your medical information to military authorities under circumstances allowed under federal and/or state laws;
- For national security and intelligence activities authorized under federal law;
- Provide your medical information to the appropriate, authorized federal officials so they may provide protection to the President, other authorized individuals, or foreign heads of state or conduct special investigations.

Workers' Compensation. We may release medical information about you as authorized by law for workers' compensation or similar programs that provide benefits for work−related injuries or illness.

Inmate or Individuals in Custody. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official. This release would be necessary for the institution to provide you with health care services; to protect your health and safety or the health and safety of others; or for the safety and security of the correctional institution.

Incidental Uses and Disclosures. There are certain incidental uses or disclosures of your information that

may occur while we are providing service to you or conducting our business. We will make reasonable efforts to limit these incidental uses and disclosures.

Other Uses and Disclosures. Other uses and disclosures of your medical information not covered above will be made only with your written authorization. If you authorize us to use and disclose your information, you may revoke that authorization at any time. Such revocation will not affect any action we have taken in reliance on your authorization. This includes uses and disclosures of psychotherapy notes and uses and disclosures for marketing purposes in which Baptist Health receives financial remuneration.

INDIVIDUAL RIGHTS

Although all records concerning your hospitalization and treatment obtained at Baptist Health are the property of Baptist Health, you have the following rights regarding the medical information we maintain about you:

Right to Request Restrictions. You have the right to request a restriction or limitation on how we use and disclose your medical information for treatment, payment, and health care operations, or to certain family members and/or friends identified by you who are involved in your care or the payment for your care. You may request that medical information regarding a particular item or specific service not be disclosed by Baptist Health to a health plan for purposes of payment or health care operations (unless required by law), if you have paid in full out−of−pocket for the item or service. We are not required to agree to any other requests. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment. We have the right to revoke our agreement at any time, and once we notify you of this revocation, we may use and/or disclose your health information without regard to any restriction or limitation you may have requested.

To request restrictions and/or limitations, you must make your request to your health care provider in writing to include (1) what information you want to limit and/or restrict; (2) whether you want to limit our disclosure, use or both; and (3) to whom you want such restrictions and/or limitations to apply.

Right to Inspect and Copy. You may request to inspect and copy much of the medical information we maintain about you, with some exceptions. If you request copies, either in paper and/or electronic format, we will charge you a copying fee plus postage. A scheduled appointment is required if you request to inspect your medical information. Any copies of your medical records requested at the time of inspection may not be made available until a later date. Any such request must be made to Baptist Health's Health Information Management Department (H.I.M.). ***See contact information below.***

Right to Request an Amendment. If you feel that the medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our entity. To request an amendment, your request must be made in writing including the reason for such request for an amendment. Your request for amending your medical information may be denied if such reasoning is not found to be sufficient or such information is determined to be accurate and complete. If your request is denied, you will be provided a written explanation for the reasoning and an advisement of your rights. Any such request must be made to H.I.M.

Right to an Accounting of Disclosures. You have the right to receive an accounting of certain disclosures

of your medical information made by us or our business associates. Any request must be submitted in writing and must state a time period which may not be longer than six (6) years. The first accounting in any 12−month period is free; however, you may be charged a reasonable fee for each subsequent accounting you request within the same 12−month period.

Breach Notification. You have the right to be notified if there is a breach of your unsecured medical information. If requested, this notification may be provided to you electronically. Baptist Health's Corporate Compliance Department and/or a business associate will provide any such breach notification as required by federal law.

Right to Request Confidential Communications. You may request that we communicate with you about your medical information in a certain way or at a certain location. We must agree to your request if it is reasonable and specifies the alternate means or location. To request confidential communications, you must make your request in writing to H.I.M. Such request must specify the method and/or address you wish to be contacted.

Sale of Medical Information. Baptist Health is prohibited from selling your medical information except under certain conditions, including exchanges for public health activities; exchanges for research and payment that reflect the costs of preparing and transmitting data for research purposes; exchanges for treatment, subject to any rules the United States Department of Health and Human Services (HHS) may promote to prevent medical information from inappropriate access, use, or disclosure; exchanges for health care operations; payment covering the cost of exchanges between Baptist Health and its business associates for activities that support our business and according to the contract with the business associate; payment for the cost of providing an individual with a copy of his or her medical information; and exchanges approved by HHS when it determines that the exchanges are necessary and appropriate. **Baptist Health may not sell your medical information for any other purpose without your authorization.**

Right to Revoke Authorization. You have the right to revoke your authorization to disclose or use your medical information except to the extent that action has already been taken in reliance on your authorization.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy of this Notice.

How to Exercise These Rights. All requests to exercise these rights must be in writing. We will follow written policies to handle requests and notify you of our decision or actions and your rights. For more information, please contact Corporate Compliance as indicated below.

ABOUT THIS NOTICE

We are required to follow the terms of the Notice currently in effect. We reserve the right to change our practices and the terms of this Notice and to make the new practices and notice provisions effective for all medical information that we maintain. Before we make such changes effective, we will make available the revised Notice by posting it in all patient registration areas, where copies will also be available. The revised Notice will also be posted on our website at www.baptistfirst.org/patient−and−visitor−information. You are entitled to receive this Notice in written form. Please contact the Corporate Compliance Office at the address listed at the end of this Notice.

COMPLAINTS

If you have concerns about any of our privacy practices or believe that your privacy rights have been violated, you may file a complaint with Baptist Health Corporate Compliance using the contact information at the end of this Notice. You may also submit a written complaint to Region IV, Office for Civil Rights, U.S. Department of Health and Human Services, Atlanta Federal Center, Suite 3B70, 61 Forsyth Street, S.W., Atlanta, GA 30303−8909. **There will be no retaliation for filing a complaint.**

CONTACT INFORMATION

Baptist Health Corporate Compliance
PO Box 244001
Montgomery, Alabama 36124−4001

corporatecompliance@baptistfirst.org
Telephone: 1−844−298−1926
Fax: 334−747−8799

MEDICAL RECORDS REQUEST

Baptist Medical Center South
Health Information Dept.
2105 East South Boulevard
Montgomery, AL 36116
(334) 286−2951

Baptist Medical Center East
Health Information Dept.
P.O. Box 241267
Montgomery, AL 36124
(334) 244−8471

Prattville Baptist Hospital
Health Information Dept.
P.O. Box 681630
Prattville, AL 36068
(334) 361−4221

If you would like to request a copy of your medical records from a physician practice, please contact that specific physician practice.

REVISION DATES

NPP6
EFFECTIVE DATE: April 14, 2003
REVISED DATE: October 1, 2005
REVISED DATE: July 5, 2006
REVISED DATE: June 14, 2010
REVISED DATE: September 23, 2013
REVISED DATE: February 16, 2015
REVISED DATE: September 15, 2016

Baptist HEALTH

NOTICE OF PRIVACY PRACTICES

You acknowledge receipt of the Notice of Privacy Practices from Baptist Health. The Notice of Privacy Practices provides information about how Baptist Health may use and disclose your protected health information. We encourage you to review it carefully. The Notice of Privacy Practices is subject to change. If the notice is changed, you may obtain a revised copy from your Baptist Health provider or by visiting our website (www.baptistfirst.org/patients−and−visitors/patient−and−visitor−information). Should you have any questions regarding your privacy rights, please consult the Notice of Privacy Practices for contact information.

_____

Please print Name (Patient's Name)

_____

Signature (Patient/Guardian/Responsible Party)

_____

Date

_____

For Baptist Health Use Only

_____

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained for one of the following reasons:

_____ Individual refused to sign

_____ An emergency situation prevented us from obtaining acknowledgement

_____ Other

Please provide a brief explanation of the reason acknowledgement was not obtained.

_____

_____

_____

_____

_____ _____

Baptist Health Staff Member (Please Print Name) Date/Time

_____

Baptist Health Staff Member (Signature)

Baptist HEALTH

Authorization to Request Medical Records

I hereby authorize the use or disclosure of my Protected Health Information (PHI) as described below**. Furthermore, I understand that my signature below specifically authorizes the release of health care information relating to testing, diagnosis or treatment for: HIV/AIDS virus, Mental health / Psychiatric Disorders, Sexually Transmitted Disease(s), Drug/Alcohol Abuse/ Treatment, if they are a part of my medical record.** I understand that this authorization is voluntary. Once this information has been disclosed, it may be subject to re−disclosure and no longer be protected by federal privacy regulations.

Patient Name: _____

Previous Name, if applicable: _____

Last 4 digits of SSN: _____ Date of Birth: _____

Email Address: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home or Cell Phone: _____ Work Phone: _____

Please note that a copy of a state or federal issued photo identification is required for processing any release of medical information.

PERSON/ORGANIZATION TO RECEIVE INFORMATION: Please send my health information to the following person/organization:

❑ Patient (Check if disclosure of information is to the same person named above)

Name (Individual or Company): _____

Telephone Number: _____ Fax Number (continuing patient care only): _____

Address: _____

City: _____ State: _____ Zip Code: _____

PURPOSE OF DISCLOSURE: ❑ Continuum of Care ❑ Personal Use ❑ Other (Please describe) _____

MEDIA TYPE: Please select which format you wish for the records to be: ❑ Electronic (CD) ❑ Paper

DELIVERY PREFERENCE: Please select one of the following delivery methods:

❑ Mail ❑ In−person pick-up ❑ Fax (another healthcare provider only)

DESCRIPTION OF HEALTH INFORMATION TO BE DISCLOSED:

Complete Medical Records Without Billing Records Date(s) of Service: _____

Complete Medical Records With Billing Records(Please Select Below) Date(s) of Service: _____

Partial Medical Record (Please Select Below) Date(s) of Service: _____

INFORMATION REQUESTING:

❑ Face Sheet
❑ Medication List
❑ Consultation Report
❑ Discharge Report
❑ Pathology Report
❑ X−ray List
❑ Medical Images / Reports
❑ Other (Describe): _____

❑ Fetal Monitors
❑ Progress Notes
❑ Clinic Notes
❑ Lab Reports
❑ Diagnostic Procedure Report
❑ Operative Report
❑ Emergency Room Record

❑ After Care Plan
❑ **All Billing Records (Check below)**
❑ *UB04*
❑ *Summary Statement*
❑ *Itemized Bill*

Baptist HEALTH

Authorization to Release Medical Records

NOTICE: If I request records in electronic format, I understand that the records on the CD or available secured portal will be encrypted to help protect my privacy and the security of my health records that the person(s) receiving these records will be furnished with the manner in which to access those encrypted records. Baptist Health is not responsible for the privacy and security of the electronic records on CD or in an email while in transit to and upon receipt by the intended recipient.

EXPIRATION OF AUTHORIZATION: Unless I request in writing otherwise, I understand that this authorization will expire on _____(insert expiration date, not to exceed six (6) months). If I do not specify an expiration date, this authorization will expire six (6) months from the date on which I signed this authorization.

RIGHT TO REVOKE AUTHORIZATION: I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Health Information Management Department at the Baptist Health facility in which I received care. I understand that the revocation will not apply to any health information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

RE−DISCLOSURE: I understand that if my health information is disclosed to a party other than a healthcare provider, health plan or health care clearinghouse subject to the federal privacy regulations, my health information disclosed pursuant to this authorization may no longer be protected by the federal privacy regulations.

FEES: I understand that federal and state laws allow a fee to be charged for the copying of patient records and I will be responsible for the payment of such fees.

REFUSAL TO SIGN: I understand that Baptist Health may not condition the provision of treatment, payment, and enrollment in a health plan, or eligibility for benefits on signing this Authorization, except under the following circumstances:
(1) Participating in research projects can be conditioned on my signing an Authorization to use and disclose PHI in the research; (2) Initial determinations; (3) Furnishing healthcare services to me at the request of a third party can be conditioned on my signing an authorization for disclosure of the PHI to the third party requesting the treatment.

RELEASE AND WAIVER: If the health information that I have requested Baptist Health to disclose contains any privileged psychiatric or psychological information related to the treatment of physical and/or mental illness, chemical dependency, alcohol abuse or treatment of any communicable or infectious disease such as acquired immunodeficiency virus (HIV), Venereal Disease, Tuberculosis or Hepatitis, I hereby waive any privilege concerning such information for the purpose(s) of releasing it to the party or parties authorized above. I also release Baptist Health and each of its facilities and their officers, trustees, agents and employees from any and all liabilities, damages and claims, which might arise from the release of the health information authorized by me above.

_____ _____

Signature of Patient (Or Patient's Representative) Date/Time

_____ _____

Printed Name (or Patient's Representative) Date/Time

_____

Relationship to the Patient (if Representative)

A copy of this completed, signed and dated form will be provided to the patient and / or patient's representative and a copy will be placed in the patient's medical record.