MONTGOMERY PRIMARY
MEDICINE ASSOCIATES

2055 East South Blvd. Suite 308
Montgomery, Alabama 36116
Telephone: 334-286-2390 Fax: 334-286-2397
Website: www.mpmadocs.com

To Our Patient
It is our goal to provide efficient and effective health care in a clean well organized facility, which places the 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: www.mpmadocs.com. 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, Gynecolgy, Minor Surgical and Dermatological Procedures, Preventive Health Care, and Geriatrics. We will see patients 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 / Annual Exams
Chronic Medical Care
Immunizations
Women's Health / GYN Exams
Acute/Minor Injuries and Illnesses
Help in Choosing the Right Specialist
Minor Procedures (In-office)
Patient Education

Office Hours and Appointments
Office hours are 7:00 a.m. to 5:00 p.m. Monday through Thursday and Friday 7:00 a.m. to 2:00 p.m.
All patients are seen by appointment only. Every second and third Wednesday of the month our office is closed from 12:00 p.m. – 2:00 p.m.

If you are a new patient to our office, it is required that you arrive 30 minutes prior to your appointment time. Patients that arrive 15 minutes after the required arrival time of their scheduled appointment will be asked to reschedule. New patients are asked to arrive 30 minutes before their scheduled appointment time to complete the necessary paperwork. If the new patient has not arrived within 15 minutes of that 30 minutes arrival time, you will be asked to reschedule.

We do not provide treatment over the phone. If you are experiencing a sudden illness or injury, you can contact the office to schedule an appointment.

Telephone
Phone hours are 7:30 a.m. to 4:30 p.m. Monday through Thursday and Friday 7:00 a.m. to 12:00 p.m.
Our goal is to efficiently route your call to the appropriate staff member. We have a very simple and easy to follow 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 as the staff member may be on the phone or away from their desk. We will do our best to return non-urgent calls in 24 to 48 hours. If you have an urgent need to call will be tended to as soon as possible, but if it is a threat to life, limb, or eyesight please call 911.

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Follow Up's and Medications

It is important that you make follow up appointments as directed by your provider. Please be sure to bring an updated list of medications or your bottled prescriptions as this allows us to have a more accurate accounting of what medications you are currently taking. During your visit you should request refills on your medications. Refills are usually sent electronically to your preferred pharmacy, unless it is a controlled substance. Controlled substances will require a written prescription and you will be asked to sign a narcotic substances contract. Any refills picked up in the office will require you to show a photo id and sign our prescription log.

Any refills for Narcotic Prescriptions must be refilled by your Primary Care Physician in the office only.

Test Results

Patients will get a call from the nurse to discuss lab results only after the provider has reviewed the results. If all test results are normal you will receive a lab letter by mail.

Form Requests

One Page (Front Only) $15 for completion. Two Pages & Beyond $25 for completion. We have a 7-10 day turn-around 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 a physician when the office is closed, call 334-288-2100 to reach the hospital operator and they will reach the physician on call. **Please reserve all after hour calls for situations that require your provider's IMMEDIATE ATTENTION. (THIS DOES NOT INCLUDE MEDICATION REFILLS).**

If it is an EMERGENCY go Directly to the Emergency Room or Call 911 !

Admissions

Our office utilizes the Baptist Hospitalist Program for our admissions to all Baptist Medical Centers. This hospital physician group consists of physicians who specialize in hospital inpatient care.

Patient Responsibilities

Please call your insurance company to let them know you are now seeing us a patient. In most cases they will need an updated card with the new PCP provider's name listed. 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 the procedure or visit, the insurance company may refuse to pay claims that you will be held responsible for.

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It is important that you keep your appointment(s) to provide the best care possible. If you are unable to keep your appointment please be sure to contact our office as soon as possible to cancel or reschedule. No shows cause a disruption in the provider's schedule and are considered non-complaint with your care. Not showing up for your appointment can result in **Dismissal** from our office.

Dismissal Rules:
New Patient - No Show twice will be Dismissed
Established Patient – No Show three times will be Dismissed

Payment Policy
Payment for patient portion of the visit (co-pays, deductibles, etc.) is collected at the time service is rendered. We accept Cash, Check, 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.

Our Patient Portal
We encourage you to sign up for our patient portal. Signing up is simple. Provide us with your updated email address the day of your scheduled appointment and at mid-night you will receive an email link to sign up. For questions or concerns regarding the patient portal call 1-877-868-1814.

Note from Clinic Manager
Thank you for selecting our office to serve your health care needs. If a situation arises and you need to reach me please feel free to contact me through the office at any time.

Samuel Saliba, M.D..
Jennifer Abt, M.D.
Wendy Nazareno M.D.
Abigail Burgess, C.R.N.P.
Karen Wyatt, 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.
- **Patient's Right to Agree to Inclusion or Opt Out Form**: 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 Acknowledgement 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 Acknowledgement 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 South Hospital Campus to help you find our office along with a picture of the building we are located in.
- As a new patient you will need to arrive 30 minutes prior to your appointment time to register. As well as bring you Insurance Card, Photo ID, Copay, and Any Medications/Vitamins you may currently be taking.

If you have any questions or concerns, please feel free to contact us at (334) 286-2390.

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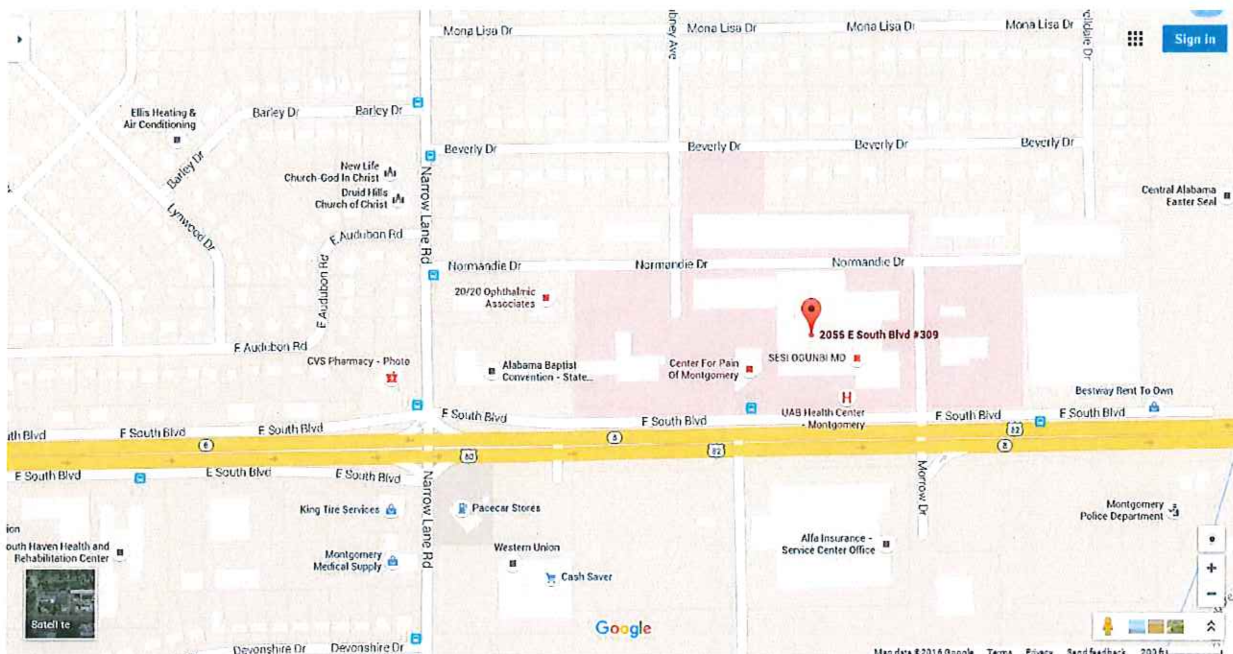

Montgomery Primary Medicine Associates

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	Brother	Sister	Grandmother	Grandfather	Children
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 ______________

SPECIALIST/OUTSIDE PROVIDER:

1. ______________ 3. ______________ 5. ______________
2. ______________ 4. ______________ 6. ______________

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. ______________

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	_____/_____	Pneumonia shot	_____/_____	Cholesterol test	_____/_____
Colonoscopy	_____/_____	Flu Shot	_____/_____	Diabetes test	_____/_____
Mammogram	_____/_____	Tetanus shot	_____/_____	TB skin test	_____/_____
Pap test	_____/_____	Hepatitis B shots	_____/_____	Thyroid Test	_____/_____
Rectal Exam	_____/_____	Stool test/blood	_____/_____	Bone Density	_____/_____
		PSA test	_____/_____		

OTHER

Do you have a living will or advanced directives? ❏ Yes ❏ No
Do you have a durable power of attorney for health care? ❏ Yes ❏ No

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Patient's Right to Agree to Inclusion or Opt Out Form

The questions below require a response to appropriately maintain patient privacy and safety:

1. Do you wish for us, in the course of your care at MPMA, to release any information regarding you and your health to:

- A family member ___Yes ___No
  Names: (please print) Relationship:
  1.________________________________ ______________
  2.________________________________ ______________

- Other Relative ___Yes ___No
  Names: (please print) Relationship:
  1.________________________________ ______________
  2.________________________________ ______________

- Close Personal Friend(s) ___Yes ___No
  Names: (please print) Relationship:
  1.________________________________ ______________
  2.________________________________ ______________

- Personal representative identified by you. If yes, please identify by name:
  1.____

Signature: ________________________________ Date:____________

Please print your name: ________________________________

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Authorization for Release of Health Information

This form is used to release your protected health information as required by federal and state privacy laws. Your authorization allows Baptist Health Physician Group to release health information to and request from an entity of your choice.

Purpose of Release: Please circle one:
Personal Use   Continued Medical Care   Changing physicians   Other:____________________

Patient Name: ____Date of Birth:______________________________

Address: ____Phone Number: ______________________________

Release Medical Information from:

Name:____________________________________

Address:__________________________________

Phone:___________________________________

Fax:_____________________________________

Release Medical Information to:

Montgomery Primary Medicine Assocaites

2055 East South Blvd, Suite 308, Montgomery, AL. 36116

Phone: (334) 286-2390

Fax: (334) 286-2397

Information to be released: Please check the appropriate option:

___All information related to the provision of and payment for my health care benefits or services.

___**Psychotherapy Notes**-Federal Law requires that a separate authorization to us or release psychotherapy notes.

___Specific Information as described below:

____

Note: State law requires that you give specific information permission to release the information below even if you select one of the options above.

Initial below to authorize the release of information.
___Substance abuse___Genetic Information___HIV/AIDS___Mental/Behavioral health

Expiration of this authorization:
___When I revoke this authorization.
___Specific date or event:____

Approval:
I understand that this authorization to release information is voluntary. I also understand that if the person or organization I authorize to receive the information described above is not subject to federal health information privacy laws, they may further release the protected health information and it may no longer be protected by federal privacy laws.

Print Name:________________________________Sign Name: ________________________________

Date:_____________________________________

Personal Representative: A Personal representative is a person who has the legal authority to act on behalf of an individual. A copy of Power of Attorney or other document must be on file at our office.

Print Name:________________________________Sign Name:________________________________

Date:_____________________________________

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 all 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 acknowledgment of receipt;
- Notify you in the case of a breach of your identifiable medical 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 (HIE). HIEs 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 a HIE 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. Baptist Health's participation in the HIE helps improve the quality of care you receive. Baptist Health may also make your health information available to other HIE services 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 by submitting a written request seeking exclusion.

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 the 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 operations of Baptist Health to ensure that all of our patients receive quality care. For instance, we may use 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 that 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 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; or
- 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.
- 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 include, for example, 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, 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 a 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).

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 sale 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 polices 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. You are entitled to receive this Notice in written form. Please contact the Corporate Compliance Office at the address listed below to obtain a

written copy.

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 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

Corporate Compliance Office	**Telephone:**	334-273-4442
	Telephone:	800-621-5966
	Fax:	334-273-4415

Baptist Health Corporate Compliance Department
301 Brown Springs Road
Montgomery, Alabama 36117

corporatecompliance@baptistfirst.org

Mailing Address:
PO Box 244001
Montgomery, Alabama 36124-4001

NPP5
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

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT OF RECEIPT

I 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). 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.

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