St. Joseph's/Candler
Physician Network

Authorization for Release of Information for Specific Purposes of HIPAA DISCLOSURE

SJ/C Physician Network - Neurology
11706 Mercy Blvd, Plaza A, Building 10, Savannah, GA 31419
P: 912-819-4949 F: 912-819-2300

I hereby authorize **SJ/C Physician Network - Neurology** to release/receive the following information from the health records of:

Patient Name:_____ **Date of Birth:** _____ **SS#** _____

Check one: ☐ Obtain From ☐ Release To

_____ _____
Name of Entity or Physician **Phone or Fax Number**

_____ _____
Street Address **City, State Zip**

Information to be released: *(Check All That Apply)*

☐ Entire Record ☐ Lab Results ☐ Nursing Notes ☐ Demographics
☐ Emergency Room Notes ☐ Radiological Results ☐ Physician Orders ☐ Medication Record
☐ Dictated Reports (H&P, Discharge Summary, OP Note, Consults, Test Results, etc.)
☐ Other _____

For dates of services rendered _____ through _____

For the purpose of: _____

I understand that I can revoke this authorization by providing written notice to the Health Information Department of St. Joseph's/Candler Physician Network at the address listed above or in a manner described in the Notice of Privacy Rights. I also understand that if information has been released by relying upon this Authorization, that revocation will not be valid.

I PLACE NO LIMITATIONS ON HISTORY OF ILLNESS OR DIAGNOSTIC AND THERAPEUTIC INFORMATION, INCLUDING ANY TREATMENT FOR ALCOHOL, DRUG ABUSE OR DEPENDENCY, PSYCHIATRIC OR PSYCHOLOGICAL ILLNESS, MENTAL ILLNESS OR RETARDATION AND ACQUIRED IMMUNE DEFICIENCY (AIDS) SYNDROME.

The physician's office listed above may not condition treatment or payment on the signing of this authorization, unless allowed by law.

I understand that I am waiving my rights to privacy by releasing my medical information to the parties listed above and this information may be re disclosed by the receiving party. I hereby authorize the entity listed above to release the said information described above.

I understand that this Release of Information will expire within **ninety (90) days** from the date listed below.

Patient Signature _____ **Date** _____

Patient's Guardian or Capacity _____ **Relation** _____ **Date** _____

For Health Information Management Department Use Only:
Date completed: _____ Method of Release: ☐ Mail ☐ Pick Up ☐ Fax Completed by: _____

St. Joseph's/Candler
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Patient Demographics

Appointment Date: _____

PATIENT INFORMATION				
Last Name	First Name	M	Preferred Name	Birthdate (MM/DD/YYYY)
Address	City	State	Zip Code	
Home Phone	Cell Phone	Work Phone	Gender ☐ Male ☐ Female ☐ Transgender	
Practice communication preference for Appts, Rx Notices, Test Results: ☐ Phone ☐ Text (SMS) ☐ Both	Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed	Social Security Number		

GUARANTOR INFORMATION (only if different from patient)				
Last Name	First Name	M	Relationship to Patient	
Address	City	State	Zip Code	
Home Phone	Mobile Phone	Birthdate (MM/DD/YYYY)	Social Security Number	

EMERGENCY CONTACT			
Relation ☐ Parent ☐ Grandparent ☐ Care Giver ☐ Child ☐ Sibling ☐ Life Partner ☐ OTHER_____	Last Name	First Name	M
Address	City	State	Zip Code
Primary Phone	Secondary Phone		

PRIMARY INSURANCE INFORMATION		
Primary Insurance Company	Policy ID Number #	Group Number # / Group Name
Coverage Start Date(MM/DD/YYYY)	Subscriber/Insured Name	Patient Relationship to Insured ☐ SELF ☐ Spouse ☐ Child ☐ Other_____

SECONDARY INSURANCE INFORMATION		
Secondary Insurance Company	Policy ID Number #	Group Number # / Group Name
Coverage Start Date(MM/DD/YYYY)	Subscriber/Insured Name	Patient Relationship to Insured ☐ SELF ☐ Spouse ☐ Child ☐ Other_____

TRICARE INSURANCE ONLY – SPONSOR INFORMATION				
Last Name	First Name	Relationship to Patient	Birthdate (MM/DD/YYYY)	Social Security #
Address	City	State	Zip Code	

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PATIENT PORTAL INFORMATION

Enable Web Portal Access	Email Address **(Required to enable)**
☐ Yes ☐ No	

Rx HISTORY CONSENT and ADVANCE DIRECTIVE

Indicate whether you consent for your provider to view your Rx history from external sources.	An Advance Directive protects your right to refuse medical treatment that you do not want or to request treatment you do want.
☐ Yes ☐ No	Do you have an Advance Directive? ☐ Yes ☐ No If NO, would you like more information? ☐ Yes ☐ No

ADDITIONAL INFORMATION

Race	Ethnicity	Primary Language
☐ Asian ☐ Black	☐ Hispanic or Latino	☐ Asian ☐ English ☐ Spanish
☐ Hispanic ☐ White	☐ Non-Hispanic or Non-Latino	☐ Sign Language (ASL)
☐ Other_____		☐ Other_____

INSURANCE PREFERRED LAB AND RADIOLOGY SERVICES

If the patient does not designate a preferred facility here, any tests will be performed at St. Joseph's/Candler facilities and the patient will be responsible for payment.

Laboratory	**Radiology**
☐ St. Joseph's/Candler ☐ LabCorp ☐ Quest	☐ St. Joseph's/Candler
☐ Other_____	☐ Other_____

PRIMARY CARE PHYSICIAN

Physician Name (Primary)	Phone #	Fax #

Address	City	State	Zip Code

PHARMACY INFORMATION

Pharmacy Name (Primary)	Phone #	Fax #

Address	City	State	Zip Code

AUTHORIZATION FOR TREATMENT and ASSIGNMENT OF BENEFITS

I do hereby consent to and authorize the performance of all treatments, surgeries and medical services deemed advisable by the healthcare providers and staff of St. Joseph's/Candler Physician Network to me or to the above-named minor of whom I am the parent or legal guardian. I hereby certify that, to the best of my knowledge, all statements contained hereon are true. I understand that I am directly responsible for all charges incurred for medical services for myself and my dependents regardless of insurance coverage. I also hereby authorize St. Joseph's/Candler Physician Network to release information requested by insurance company and/or its representatives to process my insurance claim. I fully understand this agreement and consent will continue until cancelled by me in writing.

_____ _____

Signature of Patient / Responsible Party Date

_____ _____

Printed Name of Patient / Responsible Party Relationship to Patient

St. Joseph's/Candler
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Patient Medical History

Last Name: _____ First Name: _____ Birth Date _____

Chief Complaint

What is the main reason for your visit today? *(Describe your problem in detail)* _____

_____

History of Present Illness

Location of the problem: _____ How long does the problem last? _____

When did you first notice the problem? _____

Describe the problem's intensity: ❑ Dull then sharp ❑ Very sharp then stops ❑ Constant ❑ Variable

Is anything else occurring at the same time? ❑ Yes ❑ No If yes, please explain. _____

On a scale of 0-10, with 0 being the least painful and 10 being the most painful, describe your pain. Circle the number:

Less pain More pain

0 1 2 3 4 5 6 7 8 9 10

Medical History

❑ Arthritis	❑ Gall Bladder Disease	❑ Liver Problems	❑ Tuberculosis
❑ Asthma	❑ Heart Disease/Heart Attack	❑ Thyroid Disease	❑ Reflux/Heart Burn
❑ Bleeding Disorder	❑ Stroke/Mini-stroke	❑ Lung Problems	❑ Kidney Problems
❑ Seizure Disorder	❑ High Blood Pressure	❑ Migraines	❑ Irregular Heart Beat
❑ Neck/Back Problem	❑ Diabetes	❑ Cancer: Organ _____	

Procedure History

Surgery	Date (Year)	Surgery	Date (Year)
❑ Heart Bypass/Valve Replacement	_____	❑ Stomach Surgery	_____
❑ Hernia Repair	_____	❑ Appendix Removed	_____
❑ Gallbladder Removed	_____	❑ Back/Neck Surgery	_____
❑ Joint Replacement	_____	❑ Prostate Surgery	_____
❑ Bladder/Kidney Surgery	_____	❑ Tonsils Removed	_____
❑ Organ Transplant	_____	❑ Other _____	

Family History

List all serious illnesses in your **IMMEDIATE FAMILY**. *Examples include Seizures, Headaches, Tremors, Dementia, etc.*

Illness	Relationship

How many of the following do you have?

Brothers _____ Sisters _____ Sons _____ Daughters _____

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Social History

Tobacco Use – check all that apply

❑ Current smoker Date started? _____ How often? ❑ Every day ❑ Some days

How many? ❑ 5 or less ❑ 6-10 ❑ 11-20 ❑ 21-30 ❑ 31+

How soon after you wake? ❑ Within 5min ❑ 6-30min ❑ 31-60min ❑ after 60min

Interested in quitting? ❑ Ready to quit ❑ Thinking ❑ Not ready

❑ Former smoker Date last smoked? _____

How long since last smoked? ❑ 1-3 months ❑ 3-6 months ❑ 6-12 months ❑ 1-5 years ❑ 5+ years

What type? ❑ Cigarettes ❑ Cigars ❑ Smokeless ❑ Pipe ❑ Other

❑ Never a smoked

Alcohol Use

Did you have a drink in the past year? ❑ Yes ❑ No

How often? ❑ Monthly ❑ 2-4 times mth ❑ 2-3 time week ❑ 4 or more a week

How many drinks on a typical day? ❑ 1-2 ❑ 3-4 ❑ 5-6 ❑ 7-9 ❑ 10+

How often you have 6 or more on occasion ❑ Never ❑ Monthly ❑ Weekly ❑ Daily

Illicit Drug Use

Have you used drugs other than those for medical reasons in past year? ❑ Yes ❑ No

What type? ❑ Amphetamines ❑ Cocaine ❑ Ecstasy ❑ LSD ❑ Crack ❑ Meth
❑ Prescription Opiates ❑ Heroin ❑ Marijuana ❑ Suboxone ❑ PCP

Route? ❑ Injected ❑ Intranasal ❑ Smoked

Frequency? ❑ Daily ❑ Weekly ❑ Monthly

Are you receiving treatment? ❑ Yes ❑ No

Allergies

Name of Allergy	What kind of reaction do you have?

Medications

Medication	Dose	Frequency	Reason for Medication

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I hereby authorize SJ/C Physician Network to release the following information *from* the health records of:

Patient Name: _____ DOB: _____

To the following individuals (ie, family member, friend, and so on):

Name	Relationship	Date of Birth	Phone

INFORMATION TO BE RELEASED: **(Check All That Apply)**

☐ Entire Record ☐ Lab Results ☐ Nursing Notes ☐ Demographics

☐ Emergency Room Notes ☐ Radiological Results ☐ Physician Orders ☐ Medication Records

FOR THE PURPOSE OF:

☐ Anything on behalf of patient

☐ Creating/Changing/Canceling appointments

☐ View or correct demographic information to include signing in on my behalf

☐ Receive documents containing my PHI on my behalf with an authorization for release of information signed by me.

☐ Picking up prescriptions/forms and or medications on my behalf.

☐ Speaking to SJC Physician Network staff regarding my PHI including but not limited to billing and insurance information on my behalf.

☐ Other: _____

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The physician's office listed above may not condition treatment or payment on the signing of this authorization, unless allowed by law.

I understand that I am waiving my rights to privacy by releasing my medical information to the parties listed above and this information may be re disclosed by the receiving party. I hereby authorize the entity listed above to release the said information described above.

I understand that this Release of Information will expire within ONE YEAR from the date listed below.

Patient Signature _____ Date _____

Patient's Guardian or Capacity _____ Date _____

Relationship to Patient _____

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Office Policies

Appointments and No Show Policy

We believe that our patient's time is valuable and every effort is made to keep your waiting time to a minimum. If you are unable to keep your appointment, please notify the office as soon as possible. This courtesy allows us to give appointments to another patient. If you do not **cancel your appointment at least one business day prior to the scheduled appointment time**, a **No Show fee of $50** will be charged to your account. If you have 3 or more No Shows within a 12 month period, you could be discharged from the practice.

Financial Policy

Due to changes in today's healthcare, your insurance may not always pay for all services. Please make sure you understand your insurance plan and the services that are covered.

- Your insurance card(s) and picture ID will need to be presented each time you visit our practice to assure we have the most recent information. If your insurance card is not provided, your appointment will be handled as self-pay and payment for services will be collected prior to being seen.
- Co-payments must be paid prior to seeing the healthcare provider on the date service is rendered. Patients are responsible for their deductibles or charges not reimbursed by insurance. As a courtesy to you, we file your insurance claims; therefore, it is your responsibility to provide our office with up-to-date billing information.
- Please understand that your insurance is a contract between you and your insurance company, and you are ultimately responsible for the bill. If you have not received an explanation of benefits within 30 days of seeing your healthcare provider, you are expected to contact your insurance company for an explanation as to why payment has been delayed.
- Self-pay patients are required to pay for services prior to being seen for their visit and will be billed for the remainder of the fees at the time of charge posting.
- It is understood that checks made payable to this office returned for insufficient funds, stop payments, or other reason for non-payment will be assessed a $30.00 NSF fee for which the patient will be held responsible.
- Patients with no financial ability to pay St. Joseph's/Candler charges may be screened for eligibility under Medicaid and other state programs and/or evaluated against established guidelines for financial assistance upon request. Please notify the front desk staff if you would like more information about how to apply for financial assistance.

Patient Portal

The patient portal allows patients to manage their personal health information at their own convenience. You will be able to securely and confidentially exchange non-emergent messages with our practice, request prescription refills, request and keep track of appointments, view referrals to specialists, view lab and imaging results and update your contact information.

Prescription Refills and Samples

You must contact your pharmacy directly for more expedient prescription refills. Please allow your pharmacy up to 48 hours to process your refill request. Please note that prescriptions will not be refilled after hours, on weekends, or on holidays. Some prescriptions cannot be refilled if you have not seen your healthcare provider within the last 3-6 months. If you have mail-away prescriptions, please allow 7-10 business days for the necessary forms to be completed. It is very important you plan ahead with mail-away prescriptions to allow adequate time for paperwork to be processed.

Laboratory and Imaging Results

Laboratory tests can be performed in our in-house lab, but some special tests may be sent out. You must have an appointment for lab tests and a lab order from your provider. Your healthcare provider will review your lab/imaging results and notify you via voice message, letter or your patient portal. If you have not heard from us within 7 days, please call our office.

Referrals

Most insurance plans require a patient to be seen by their primary care provider prior to seeing a specialist. If your insurance plan requires a prior authorization, you must verify your insurance has approved the visit before seeing the specialist. Otherwise, you will be responsible for any incurred charges.

Medical Records

Please note that requests for any health information cannot be processed without a signed medical record release from the patient or legal representative. This service is outsourced and processed weekly. Please allow up to 7 business days for your request to be processed. A fee may be charged for this service.

Patient Consent and Signature

I have read and understand the office policies of the practice and agree to be bound by its terms and conditions. I also understand and agree that such terms may be amended occasionally by the practice.

Patient Signature _____ Date _____

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Joint Notice of Privacy Practices

The following organizations use health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive through healthcare operations. The Organizations who are covered under this Notice include St. Joseph's/Candler Physician Network.

How We May Use or Disclose Your Health Information:
For Treatment. We will use your protected health information to provide, coordinate, or manage your medical treatment and services. For example, we may disclose protected health information to another physician or health care provider who becomes involved in your care. This information is necessary for health care providers to determine what treatment you should receive.

For Payment. We will use protected health information for purposes of obtaining payment for treatment and services that you receive. For example, a bill may be sent to you or a third party, such as an insurance company. The information on the bill may contain information that identifies you, your diagnosis, and treatment or supplies used in the course of treatment.

For Health Care Operations. We may use and disclose health information about you for operational purposes. For example, your health information may be disclosed to evaluate the performance of our staff; assess the quality of care; learn how to improve our facilities and services. This includes sending information to a third-party to conduct research on patient satisfaction and effectiveness of the services performed.
We may use or disclose your information to provide appointment reminders. We may call you by name in the waiting room when the provider is ready to see you.
We may use or disclose your protected health information to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest.

Appointments. We may use your information to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to the individual.

Required by law. We may use and disclose information about you as required by law. For example, for judicial and administrative proceedings pursuant to legal authority; to report information related to victims of abuse, neglect or domestic violence; and to assist law enforcement officials in their law enforcement duties.

Public Health. Your health information may be used or disclosed to a public health authority who is permitted by law to collect or receive this information. The disclosure may be necessary to prevent or control disease, injury, or disability, or for other health oversight activities.

Required by law. We may use and disclose information about you as required by law. For example, for judicial and administrative proceedings pursuant to legal authority; to report information related to victims of abuse, neglect or domestic violence; and to assist law enforcement officials in their law enforcement duties

Funeral Directors/Coroners. Health information may be disclosed to funeral directors or coroners to enable them to carry out their lawful duties.

Health and Safety. Your health information may be disclosed to avert a serious threat to the health or safety of you or any other person pursuant to applicable law.

Government Functions. Your health information may be disclosed for specialized government functions such as protection of public officials or reporting to various branches of the armed services.

Workers Compensation. Your health information may be used or disclosed in order to comply with laws and regulations related to Workers' Compensation.

Other uses. Other uses and disclosures will be made only with your written authorization and you may revoke the authorization except to the extent SJC Physician Network, Inc. and this physician's office has taken action in reliance on such.

<u>Your Rights to Privacy</u>
You have the right to request a restriction on certain uses and disclosures or your information. However, the

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organizations listed above are not required to agree to a requested restriction.

You have the right to obtain a paper copy of the Notice of Privacy Practices upon request to the Privacy Official or a member of the organization.

You have the right to inspect and obtain a copy of your health record as allowed by state and federal regulations.

You may request an amendment to your health record as allowed by state and federal regulations.

You may also request communications of your health information by alternative means or at alternative locations. For example, by sending information to a P.O. Box instead of your home address.

You may revoke your Authorization to use or disclose health information except to the extent that action has already been taken by providing written notice to the Medical Record Department, SJC Physician Network, Inc. at this office site address.

You may receive an accounting of disclosures made of your health information as provided by federal regulations by sending a written request to the Medical Record Department at the address listed above. Your request must state a time period which may be no longer than six years and may not include dates before April 14, 2003.

If you have a concern or complaint about your privacy rights: Contact the Privacy Official at 5353 Reynolds Street, Savannah, Georgia 31405.

You may also contact the Department of Health and Human Services, if you believe your privacy rights have been violated. You will not be retaliated against for filing a complaint.

Our Obligations Under This Joint Notice

We are required by law to maintain the privacy of protected health information and to provide you with a Notice of our legal duties and privacy practices with respect to the protected health information. We will accommodate reasonable requests you may make to communicate health information by alternative means or at alternative locations. For reasons other than those stated above or as allowed by law, we will obtain your written authorization to use or disclose your health information. We will notify you if we are unable to agree to a requested restriction on how your information is used or disclosed. We are also required to comply with the terms of the Notice currently in effect.

We reserve the right to change our information practices and to make the new provisions effective for

all protected health information we maintain. The revised notice will be made available to you by requesting a copy of an updated Notice. You may send a written request to the Privacy Official at 5353 Reynolds Street, Savannah, Georgia 31405.
You may also view this notice on your website, www.sjchs.org.

This Notice of Privacy Rights is effective on
April 14, 2003.

By signing this document, I hereby acknowledge that I have received a copy of the St. Joseph's / Candler Health System, Inc. Joint Notice of Privacy Rights.

_____
Patient Signature

_____
Patient Printed Name

_____
Guardian Signature: (if applicable)

_____
Relationship to the Patient

Date: _____

OR:

Reason Acknowledgement was not obtained:

_____

_____

_____

_____
Witness

_____
Witness

Date: _____