

Patient Registration Form

PATIENT INFORMATION

Full legal name (First, Middle, Last, suffix) _____		Nickname _____	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Date of birth _____	Social security number _____	Race _____	Preferred language _____
Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic Marital status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Life partner			
Complete mailing address: _____ (Street, city, state, zip code, county)			
Home phone number: _____	Cell phone number: _____	Work number: _____	
Email: _____			
Employment status: <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Active duty <input type="checkbox"/> Self-employed <input type="checkbox"/> Not employed <input type="checkbox"/> Retirement date: _____			
Employer name: _____		Employer phone number: _____	
Employer complete address: _____ (Street, city, state, zip code)			

SPOUSE OR GUARANTOR INFORMATION (Responsible party) Same as patient

Full legal name (First, Middle, Last, suffix) _____		Date of birth _____	Social security number _____
Relation to patient: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Legal guardian <input type="checkbox"/> Other: _____			Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Home phone number: _____	Cell phone number: _____	Work number: _____	
Complete mailing address – if different from patient: _____ (Street, city, state, zip code, county)			
Employment status: <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Active duty <input type="checkbox"/> Self-employed <input type="checkbox"/> Not employed <input type="checkbox"/> Retirement date: _____			
Employer name: _____		Employer phone number: _____	
Employer complete address: _____ (Street, city, state, zip code)			

EMERGENCY CONTACT INFORMATION

Name (First, Last): _____			
Relation to patient: <input type="checkbox"/> Spouse <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Legal guardian <input type="checkbox"/> Other: _____			
Home phone number: _____	Cell phone number: _____	Work number: _____	
Complete mailing address – if different from patient: _____			

INSURANCE INFORMATION Self-pay (no insurance)

Primary insurance: _____	Patient relation to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other: _____
Secondary insurance: _____	Patient relation to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other: _____
Prescription/Rx provider: _____ (if different from insurance carrier)	
Full name of subscriber: _____ (complete below if different from patient, spouse or guarantor)	
Subscriber date of birth: _____	
Employment status: <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Active duty <input type="checkbox"/> Self-employed <input type="checkbox"/> Not employed <input type="checkbox"/> Retirement date: _____	
Employer name: _____	Employer size: <input type="checkbox"/> 0 – 19 employees <input type="checkbox"/> 20 – 99 <input type="checkbox"/> 100+
Employer complete address: _____ (Street, city, state, zip code)	

Primary care physician: _____	Do you want anyone to know you are here? <input type="checkbox"/> Yes or <input type="checkbox"/> No
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Neurosurgery

MEDICATION AGREEMENT

The purpose of this agreement is to let you know the requirements for receiving prescription medications from Piedmont Neurosurgery. This agreement is between the patient and providers of the office. If you do not understand this fully, please speak to your provider. By signing this form you are indicating that you understand and will comply with these guidelines.

Due to recent changes with the DEA, narcotic prescriptions are limited for certain situations. Also, know that we must review the PDMP database before prescribing narcotics or benzodiazepines that will last more than three days.

- All medications are to be taken as per the schedule indicated on the bottle. Prescribed medications can be deadly if taken incorrectly. Contact our office should you have any questions about the directions/schedule. Do not alter your medications without speaking to us.
- Early refills will not be granted unless there is documentation that our staff instructed you to increase the dosage.
- You will need to choose only one pharmacy for your medications. Please alert our staff if you are changing pharmacies so that we can make the corrections. Provide us with the name, number, and location of your pharmacy.
- If one of our providers prescribes narcotic medication for you, it is understood that you will not receive narcotic medication from any other provider outside of this practice. If we receive information that you have been getting medications from other providers Piedmont Neurosurgery will no longer provide these.
- We will not replace lost or stolen medications.
- Request for refills of medications are taken during normal business hours 8am-4pm. We will not refill medications after office hours or on weekends. When you call for a refill, please have the medication name and strength available. We will send this by email (except for certain narcotic medications) to the pharmacy on file unless you indicate otherwise to us. We will only call you back if the medication request is denied or if there has been a change in the prescription recommended by your provider. Otherwise check with your pharmacy to see when it can be picked up.
- Narcotic medications now require written prescriptions that will need to be picked up or mailed. With this in mind, please call the office a few days before you run out.
- Our providers will not refill medications if you have not been seen in the last 6 months.
- Narcotics are usually reserved for postoperative treatment and not prescribed routinely by Piedmont Neurosurgery for non-surgical issues.

This agreement is to ensure patient safety as well as to comply with the regulations of the Georgia Drug Enforcement Agency.

Patient or Legal Guardian's Signature

Witnessed By

Today's Date



Privacy Questionnaire

Patient Full Name: _____ DOB: _____

Current Address: _____

Please review and answer the following questions in regards to your protected health information.

The contact information and phone numbers you provide will be used as agreed to below. Please note that the information will be in effect for both Piedmont Physicians and Piedmont Heart Institute locations as applicable.

1. I give permission to leave a detailed message regarding my healthcare on the phone number provided below:

Phone number: _____

Phone number: _____

No please only leave a callback name and number when you attempt to reach me.

2. I give permission to discuss my medical information with the following individuals:

• Name: _____ Relationship: _____

• Name: _____ Relationship: _____

• Name: _____ Relationship: _____

• Name: _____ Relationship: _____

Authorization Signatures:

Your signature below further indicates your understanding that this authorization will be valid for a period of one year from today's date and will expire at that time unless another form is completed. You may revoke or request changes to this authorization at any time by completing a new Privacy Questionnaire.

Patient/Legal Representative
Signature

Patient/Legal Representative
Name (**PRINT**)

Date

Time

Relationship to Patient

Reason Patient is unable to sign



NOTICE OF PRIVACY PRACTICES

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.

Piedmont Healthcare, Inc. and its affiliates, including its Hospitals, Clinics, Employed Physicians, our foundations and other facilities ("Piedmont Providers") are all committed to keeping your health information private. We are required by the federal Privacy Rule to protect your medical information (called "protected health information" or "PHI") and to provide you with this Notice of Privacy Practices (the "Notice") describing our legal duties and privacy practices. Piedmont Healthcare professionals, employees, students, volunteers and business associates are all required to follow our privacy practices in caring for our patients. In certain circumstances, pursuant to this Notice, patient authorization or applicable laws and regulations, PHI can be used by Piedmont Providers or disclosed to other parties as described below.

Uses and Disclosures for Treatment, Payment and Health Care Operations: Piedmont Providers may use or disclose your PHI for the purposes of treatment, payment and health care operations, described in more detail below, without obtaining written authorization from you.

For Treatment: Piedmont Providers may use and disclose PHI in the course of providing, coordinating or managing your medical treatment, including the disclosure of PHI for treatment activities of another health care provider. For example, if you are being treated by a primary care physician, that physician may need to use/disclose PHI to a specialist physician whom he or she consults regarding your condition, or to a nurse who is assisting in your care.

For Payment: Piedmont Providers may use and disclose PHI in order to bill and collect payment for the health care services provided to you. For example, a Piedmont Provider may need to give PHI to your health plan in order to be reimbursed for the services provided to you. We may also disclose PHI to our business associates, such as billing companies, and claims processing companies.

For Health Care Operations: Piedmont Providers may use and disclose PHI as part of their operations, including for quality assessment and improvement, such as evaluating the treatment and services you receive and the performance of our staff in caring for you. Other activities include training, learning purposes, compliance and risk management activities, planning and development and administration.

For Medical Research: Research is vital to the advancement of medical science. Federal regulations permit use of PHI in medical research, either with your authorization or without your authorization when the research study is reviewed and approved by an Institutional Review Board or privacy board before any study begins, or for reviews preparatory to research as permitted by law, or for research on decedent's information as permitted by law.

As Required by Law and Law Enforcement: Piedmont Providers may use or disclose your PHI when required by law without your authorization. We may also disclose PHI when ordered to in a judicial or administrative proceeding, in response to subpoenas or discovery requests, to identify or locate a suspect, fugitive, material witness or missing person, when dealing with gunshot and other wounds, about criminal conduct, to report a crime, its location or victims, or the identity, description or location of a person who committed a crime or for other law enforcement purposes.

For Public Health Activity: Piedmont Providers may disclose PHI to government officials in charge of collecting

information about births and deaths, preventing and controlling disease, reports of child abuse or neglect and of other victims of abuse, neglect or domestic violence, reactions to medications or product defects or problems, or to notify a person who may have been exposed to a communicable disease or may be at risk of contracting or spreading a disease or condition.

For Health Oversight Activities: Piedmont Providers may use or disclose certain information to the government for authorized oversight activities including inspections, audits, licensure and other investigations of our providers or related matters.

Organ, Eye and Tissue Donation: Piedmont Providers may release PHI to organ procurement organizations to facilitate organ, eye and tissue donation and transplantation.

Coroners, Medical Examiners, Funeral Directors and Individuals Involved in Your Health Care or Payment for Your Health Care: Piedmont Providers may disclose PHI to coroners, medical examiners and funeral directors for the purpose of identifying a decedent, determining a cause of death or otherwise as necessary to enable these parties to carry out their duties consistent with applicable law.

Uses and Disclosures for Involvement in Your Care: Unless you object, Piedmont Providers may disclose your PHI to a family member, other relative, friend or other person you identify as involved in your health care or payment for your health care. We may use or disclose information to family members or others involved in the care of deceased individuals. We may also notify those people about your location or condition. Upon request, PHI may be released fifty (50) years after an individual's death.

To Avoid a Serious Threat to Health or Safety or in Disaster Relief Efforts: Piedmont Providers may use and disclose PHI to law enforcement personnel or other appropriate persons, to prevent or lessen a serious threat to the health or safety of a person or the public. We may also disclose information about you to an organization assisting in disaster relief efforts so that your family can be notified about your location, condition and status. If you do not want us to disclose information for disaster relief efforts, we will not do so unless we must respond in an emergency.

Specialized Government Functions: Piedmont Providers may use and disclose certain PHI if you are military personnel or a veteran. We may also disclose PHI to authorized federal officials for intelligence, counterintelligence and other national security activities, and for the provision of protective services to the President or other authorized persons or foreign heads of state.

Workers' Compensation: Piedmont Providers may disclose PHI to comply with workers' compensation or other similar laws that provide benefits for work-related injuries or illnesses.

Fundraising Efforts: Your PHI may be used to contact you or may be disclosed for Piedmont Provider fundraising efforts. Such disclosure would be limited to demographic information, such as your name, address, other contact information such as your phone number, age, gender and date of birth, the dates you required treatment or services at a Piedmont Provider, department of service information, treating physician, outcome information and health insurance status. You have a right to opt out of receiving such fundraising communications and in the event you are contacted for fundraising, you will be given the opportunity to opt out.

Appointment Reminders, Follow-Up Care and Treatment Alternatives: We may use or disclose your information to remind you about appointments or treatment alternatives that may be useful to you.

Patient Directories: Unless you object, we may use some of your PHI to maintain a directory in our facilities. This information may include your name, your location in the facility, your general condition (e.g. fair, good, etc.) and your religious affiliation, and the information may be disclosed to members of the clergy. Except for religious affiliation, the information may be disclosed to other persons who ask for you by name.

Uses and Disclosures of PHI For Which Authorization is Required: Other types of uses and disclosures of your PHI not described in this Notice will be made only with your written authorization, which you have the limited right to revoke in writing. Piedmont Providers may not use and disclose your PHI for marketing purposes except in limited circumstances as authorized by law or unless you have given us written authorization. We will not disclose psychotherapy notes except in limited circumstances either with your written authorization or as applicable law permits. Piedmont Providers will not sell your PHI unless we have your written authorization or applicable law permits.

Your Rights Regarding Your PHI: You may request that a Piedmont Provider restrict certain uses and disclosures of your PHI. We are not required to agree to a requested restriction except we must agree to a requested restriction of disclosure regarding your PHI to a health plan for payment purposes if the following conditions are met: (1) you have paid in full in advance for the associated treatment or services, (2) disclosure is not otherwise required by law and (3) you have made this request for restriction in writing when the services are performed. Piedmont cannot terminate a requested restriction of disclosure regarding your PHI to a health plan for payment purposes.

Confidential Communications: You may request that we communicate with you in a certain manner. For instance, you may request that we send you follow-up information at your home address instead of using your work address. We will accommodate reasonable requests regarding confidential communications as requested.

Right to Access Records: Generally, you have the right to inspect and copy the designated health information maintained by Piedmont about you. We require that you make a written request to the medical records department for your Piedmont Provider. We will provide you access in the format requested, if we can readily do so. For instance, you can request a paper copy of your records. If you ask for an electronic copy of your records, we will provide an electronic copy in the format you request if possible. If we cannot provide the records in the particular format, we will contact you to find another reasonable method. Within thirty (30) days of your written request for access, unless extended by an additional thirty (30) days, Piedmont will inform you of the extent to which your request is granted. In some cases, the Piedmont Provider may prepare a summary of the required medical information, if you inform us of your preference and agree in advance to a preparation fee for the summary. If you want a copy of your records, we may charge you a reasonable fee to cover copying, postage or other reasonable expenses with preparing a paper or electronic record or summary for you. If the Piedmont Provider denies you access to your record, we will provide you with the basis for the denial and your opportunity to have that denial reviewed by a licensed health care professional who was not involved in the initial decision review the denial. If the Piedmont Provider does not

maintain the medical information that you request and we know where that information is, we will let you know where to redirect your request for access.

Right to Request Amendment: If you believe that your PHI maintained by a Piedmont Provider contains an error, you have the right to request that the entity correct or supplement your PHI. You must send a written request to the Director of Medical Records for the Piedmont Provider to explain why you want to amend your record. Within sixty (60) days of receiving your request (unless extended by an additional thirty (30) days), the Piedmont Provider will inform you of the extent to which your request has or has not been granted. Piedmont Providers generally can deny your request if your request relates to PHI: (i) not created by the entity; (ii) that is not part of the records the entity maintains; (iii) that is not subject to being inspected by you; or (iv) that is accurate and complete. If your request is denied, the Piedmont Provider will give you a written denial that explains the reason for the denial and your rights to: (i) file a statement disagreeing with the denial; (ii) if you do not file a statement of disagreement, submit a request that any future disclosures of the relevant PHI be made with a copy of your request and the entity's denial attached; and (iii) complain about the denial.

Right to Accounting of Disclosures: You generally have the right to request and receive a list of disclosures of your PHI a Piedmont Provider has made during the six (6) years prior to your request (but not before April 14, 2003). The list will not include disclosures (i) for which you have provided a written authorization; (ii) for treatment, payment and health care operations; (iii) made to you; (iv) for a Piedmont Provider's patient directory or to persons involved in your health care; (v) for national security or intelligence purposes; (vi) to correctional institutions or law enforcement officials; or (vii) of a limited data set. You should submit any such request to the Privacy Officer, and within sixty (60) days of receiving your request (unless extended by an additional thirty (30) days), the Piedmont Provider will respond to you regarding the status of your request. The entity will provide the list to you at no charge, but if you make more than one request in a year you will be charged a fee of \$25.00 for each additional request.

Breach Notification: We are required to notify affected individuals in the event there is a breach of unsecured protected health information.

Notice of Privacy Practices Copy: You have the right to receive a paper copy of this notice upon request, even if you have agreed to receive this notice electronically. You can review and print a copy of this Notice at any Piedmont Healthcare Web site via www.piedmont.org or you may request a paper copy of this notice by contacting the Privacy Officer as described below. Please note that Piedmont, as a covered entity under the federal Privacy Rule is required to abide by the terms of the Notice in effect; however, Piedmont may revise this Notice in accordance with the law and make any changes applicable for all protected health information that Piedmont maintains. If you believe your privacy rights with respect to your PHI have been violated you have the right to contact the Privacy Officer and submit a written complaint. Piedmont Providers will not penalize you or retaliate against you for filing a complaint regarding their privacy practices. You also have the right to file a complaint with the Secretary of the Department of Health and Human Services.

If you have any questions about this notice: Please contact the Piedmont Healthcare Privacy Officer at (404) 425-7350; e-mail: privacy.officer@piedmont.org. address: 1800 Howell Mill Road, Suite 350, Atlanta, GA 30318
EFFECTIVE: March 1, 2003 REVISED: February 11, 2013 [34747P Rev. 08/13]



Patient Label

ACKNOWLEDGMENT OF RECEIPT OF "NOTICE OF PRIVACY PRACTICES"

ACKNOWLEDGMENT OF RECEIPT OF "NOTICE OF PRIVACY PRACTICES"

I hereby acknowledge that I have received a copy of the Piedmont Providers' "Notice of Privacy Practices."

Print Name of Patient

Signature of Patient or Patient's Authorized Representative Date _____ Time _____

As the Patient's Authorized Representative, my relationship with the Patient is: _____

The Patient is unable to sign because: _____

_____ OR _____

CERTIFICATION OF GOOD FAITH EFFORTS TO OBTAIN ACKNOWLEDGMENT

I hereby certify that, as an employee or agent of the Piedmont Providers, I have made a good faith effort to obtain from the patient or the patient's authorized representative a written acknowledgment of the Piedmont Providers' "Notice of Privacy Practices" in accordance with the policy titled "Provision of the Notice of Privacy Practices."

Print Name of Employee/Agent and Department

Signature of Employee/Agent Date _____ Time _____

Reason(s) For Not Obtaining Acknowledgment:



Patient Financial Agreement and Responsibilities

Patient Label

Piedmont Healthcare is committed to providing patients with information regarding their coverage and financial responsibilities. In consideration of services provided by Piedmont Healthcare (PHC), the Patient or undersigned representative acting on behalf of the Patient agrees to the following:

1. Emergency and Labor Services

Patient understands his/her right to receive an appropriate medical screening exam performed by a doctor or other qualified medical professional to determine whether Patient is suffering from an emergency medical condition, and if such a condition exists, stabilizing treatment within the capabilities of the PHC staff and facilities, even if Patient cannot pay for these services, does not have medical insurance or Patient is not entitled to Medicare or Medicaid.

2. Non-Medicare Patient Responsibility for Payment

In return for **Medical Treatment/Services** rendered to the Patient or any infant(s) born to the Patient, Patient understands and unconditionally agrees to the following:

- Patient agrees to pay all co-payments, deductibles or co-insurances.
- Patient understands and agrees that he/she will be charged the PHC standard charge master rates for all services not covered by a Payor or that are self-pay.
- Patient understands that he/she may qualify for financial assistance. For more information, the patient may contact a local financial counseling resource, call the PHC Customer Service Center (1-855-788-1212), online at www.piedmont.org or via email at assistance@piedmont.org.
- Patient specifically agrees to pay for any services, which are determined not to be covered by any health benefit plan or insurance company.
- Patient is aware that he/she is not relieved of liability by any extension of time granted for the payment of these charges, not by the acceptance by the PHC of a note of the patient or any third person.
- If PHC requires legal assistance to collect an account, Patient agrees to pay the cost incurred for such collections.
- PHC may use data from third parties such as credit reporting agencies in order to verify demographic data or evaluate financial options and by this authorization expressly permit sources and employers to provide PHC with all information requested.

3. Assignment of Insurance or Health Plan Benefits

Patient acknowledges the assignment and authorization for direct payment to PHC for all insurance and health plan benefits and settlements whether hospital, medical or liability insurance including but not limited to, the proceeds of any settlement or judgment of any third party claim as payment for any and all services performed at a PHC entity. Patient agrees that the insurance company's or health plan's payment to PHC pursuant to this authorization shall discharge the insurance company's or health plan's obligations to the extent of such payment.

4. Filing of Third Party Claims

Patient acknowledges that upon proof of coverage PHC will submit a claim for payment of insurance benefits and accept payments from third party payors ("Payors") to be credited to Patient's account as they are received. Patient agrees that the filing of insurance claims is performed as a service and in no way relieves Patient of the obligation to pay in full. Additionally the Patient acknowledges the following:

- Patient is responsible to follow up with any insurance company or employer within 30 days to see that Patient's bill is paid promptly.
- Patient understands that he/she is financially responsible for charges not paid according to this agreement. If Patient overpays the amount owed on his/her account, Patient assigns credit to be applied to any other existing unpaid accounts ("Other Accounts") for which the Patient or the insured or guarantor is also responsible. Any money remaining after the Patient's account and Other Accounts have been paid in full will be refunded to the patient or guarantor.
- Insurance companies will often deny claims when the insurance is not presented at the time of service. Please contact our Customer Solution Center with your Insurance/Payor information at 1-855-788-1212. Otherwise your account may be considered self-pay/uninsured and you will be responsible for the total bill.

5. Assignment of Medicare Benefits

Patient certifies that the information given in applying for payment under Title XVIII of the Social Security Act is correct. Patient requests that the payment of authorized benefits be made on Patient's behalf to the provider of Medical Treatment/Services. Patient assigns the benefits payable for Medical Treatment/Services rendered by PHC and all Healthcare Professionals rendering care and/or treatment to Patient and authorizes PHC and Healthcare Professionals to submit claims to Medicare for payment. Patient authorizes any holder of medical or other information to release to Medicare and its agents any information needed to determine these benefits or benefits for related services. Patient understands he/she is responsible for any deductibles, co-payments and/or non-covered services as defined by Medicare to be paid in accordance with all terms and conditions specified herein.

6. Assignment of Medicaid Benefits

Patient certifies that the information given in applying for payment under Title XIX of the Social Security Act is correct. Patient authorizes any holder of medical or other information to release to the Social Security Administration or its intermediaries or carriers any and all information needed for this or related Medicaid claims. Patient requests payment of authorized benefits be made on Patient's behalf to the provider of Medical Treatment/Services. Patient assigns the benefits payable for Medical Treatment/Services rendered by PHC and all Healthcare Professionals rendering care and/or treatment to Patient and authorizes PHC and Healthcare Professionals to submit claims to Medicaid for payment.

7. Authorization to Release Information

PHC is authorized to release information contained in the patient record. The information authorized to be released shall include, but is not limited to, infectious or contagious disease information, including HIV or AIDS-related evaluations, diagnosis or treatment; information about drug or alcohol abuse or treatment of same and/or psychiatric or psychological information. Patient waives any privilege pertaining to such confidential information. PHC, its agents and employees are hereby released from any and all liabilities, responsibilities, damages, claims and expenses arising from the release of information as authorized above. Reasons for releasing a Patient's record include, but are not limited to, insurance company(s), their agents or other third party payor and/or government or social service agencies which may or will pay for any part of the medical/hospital expenses incurred or authorized by representatives of PHC, as mandated by law, or to alternate care providers, including community agencies and services, as ordered by Patient's physician or as requested by Patient or Patient's family for post-hospital care. **PATIENT ACKNOWLEDGES AND AGREES THAT PATIENT'S RECORDS WILL BE AVAILABLE TO ALL PHC AFFILIATED ENTITIES AND PROVIDERS, AND TO NON-PHC AFFILIATED REFERRING PROVIDERS IN COMPLIANCE WITH THE PROVISIONS OF MEANINGFUL USE.** Patient also agrees, in order for PHC to service accounts or to collect liabilities owed, to receive contact by telephone at any telephone number associated with their record, including wireless telephone numbers, which could result in charges to Patient. PHC or its agents may also contact Patient by sending text messages or emails, using any email address Patient provides. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

8. Consent Timeframe and Applicability

The above agreements are applicable to all inpatient or outpatient hospital-based services and all ambulatory or physician office-based services and are valid for a term of one (1) year from the date of signature below. The same *agreement* applies to delivered infant(s) while a patient of PHC.

Validity of Form

Patient acknowledges that a copy or an electronic version of this document may be used in place of and is as valid as the original. **The patient confirms that he/she has read and understood and accepted the terms of this document and he/she is the patient, the patient's legal representative or is duly authorized by the patient as the patient's general agent to execute the above and accept its terms.**

Patient/Patient Representative Signature

Patient Name (PRINT)

Date

Time

Relationship to Patient

Reason Patient is unable to sign

Piedmont Healthcare Representative Signature

Piedmont Healthcare Representative Name (PRINT)

Date

Time



Conditions of Service and Consent for Treatment

IMPORTANT: DO NOT SIGN THIS FORM WITHOUT READING AND UNDERSTANDING ITS CONTENTS.

In consideration of services provided by Piedmont Healthcare (PHC), the Patient or undersigned representative acting on behalf of the Patient agrees and consents to the following:

1. Consent to Routine Medical Treatment/Services

Patient consents to the rendering of Medical Treatment/Services as considered necessary and appropriate by the attending physician or other practitioner, a member of the PHC medical staff who has requested care and treatment of Patient, and others with staff privileges at PHC. Medical Treatment/Services may be performed by "Healthcare Professionals" (physicians, nurses, technologists, technicians, physician assistants or other healthcare professionals). Patient authorizes the attending or other practitioner, the medical staff of PHC and PHC to provide Medical Treatment/Services ordered or requested by attending or other practitioner and those acting in his or her place. **The consent to receive "Medical Treatment/Services" includes, but is not limited to: hospital care; examinations (x-ray or otherwise); laboratory procedures; medications; infusions; transfusions of blood and blood products; drugs; supplies; anesthesia; surgical procedures and medical treatments; radiation therapy; recording/filming for internal purposes (i.e., identification, diagnosis, treatment, performance improvement, education, safety, security) and other services which Patient may receive.** In the event PHC determines that Patient should provide blood specimens for testing purposes in the interest of the safety of those with whom Patient may come in contact; Patient consents to the withdrawing and testing of Patient's blood and to the release of test information where this is deemed appropriate for the safety of others.

2. Legal Relationship between Hospital and Physician

Some of the health care professionals performing services at PHC hospitals are independent contractors and are not PHC agents or employees. Independent contractors are responsible for their own actions and PHC shall not be liable for the acts or omissions of any such independent contractors.

3. Explanation of Risk and Treatment Alternatives

Patient acknowledges that the practice of medicine is not an exact science and that **NO GUARANTEES OR ASSURANCES HAVE BEEN MADE TO THE PATIENT** concerning the outcome and/or result of any **Medical Treatment/Services**. While routinely performed without incident, there may be material risks associated with each of these **Medical Treatment/Services**. Patient understands that it is not possible to list every risk for every **Medical Treatment/Services** and that this form only attempts to identify the most common material risks and the alternatives (if any) associated with the **Medical Treatment/Services**. Patient also understands that various Healthcare Professionals may have differing opinions as to what constitutes material risks and alternative **Medical Treatment/Services**. ***By signing this form:***

Patient consents to Healthcare Professionals performing **Medical Treatment/Services** as they may deem reasonably necessary or desirable in the exercise of their professional judgment, **including those Medical Treatment/Services that may be unforeseen or not known to be needed at the time this consent is obtained;** and Patient acknowledges that Patient has been informed in general terms of the nature and purpose of the **Medical Treatment/Services**; the material risks of the **Medical Treatment/Services** and practical alternatives to the **Medical Treatment/Services**.

The **Medical Treatment/Services** may include, but are not limited to the following:

- a). **Needle Sticks**, such as shots, injections, intravenous lines or intravenous injections (IVs). The material risks associated with these types of Procedures include, but are not limited to, nerve damage, infection, infiltration (which is fluid leakage into surrounding tissue), disfiguring scar, loss of limb function, paralysis or partial paralysis or death. Alternatives to Needle Sticks (if available) include oral, rectal, nasal or topical medications (each of which may be less effective).
- b). **Physical Tests, Assessments and Treatments** such as vital signs, internal body examinations, wound cleansing, wound dressing, range of motion checks and other similar procedures. The material risks associated with these types of Procedures include, but are not limited to, allergic reactions, infection, severe loss of blood, muscular-skeletal or internal injuries, nerve damage, loss of limb function, paralysis or partial paralysis, disfiguring scar, worsening of the condition and death. Apart from using modified Procedures, no practical alternatives exist.
- c). **Administration of Medications** via appropriate route whether orally, rectally, topically or through Patient's eyes, ears or nostrils, etc. The material risks associated with these types of Procedures include, but are not limited to, perforation, puncture, infection, allergic reaction, brain damage or death. Apart from varying the method of administration, no practical alternatives exist.
- d). **Drawing Blood, Bodily Fluids or Tissue Samples** such as that done for laboratory testing and analysis. The material risks associated with this type of Procedure include, but are not limited to, paralysis or partial paralysis, nerve damage, infection, bleeding and loss of limb function. Apart from long-term observation, no practical alternatives exist.
- e). **Insertion of Internal Tubes** such as bladder catheterizations, nasogastric tubes, rectal tubes, drainage tubes, enemas, etc. The material risks associated with these types of Procedures include, but are not limited to, internal injuries, bleeding, infection, allergic reaction, loss of bladder control and/or difficulty urinating after catheter removal. Apart from external collection devices, no practical alternatives exist.
- f). **Radiological Studies** such as X-rays, CT scans or MRI scans. The material risks associated with these types of Procedures include, but are not limited to, radiation exposure.

If Patient has any questions or concerns regarding these **Medical Treatment/Services**, Patient will ask Patient's attending provider to provide Patient with additional information. Patient also understands that Patient's attending or other provider may ask Patient to sign additional informed consent documents concerning these or other **Medical Treatment/Services**.

4. Emergency and Labor Services

Patient understands Patient's right to receive an appropriate medical screening exam performed by a doctor, or other qualified medical professional, to determine whether Patient is suffering from an emergency medical condition, and if such a condition exists, stabilizing treatment within the capabilities of the PHC's staff and facilities, even if Patient cannot pay for these services, does not have medical insurance or Patient is not entitled to Medicare or Medicaid.

5. Healthcare Practitioners in Training

Patient recognizes that among those who may attend Patient at PHC are medical, nursing and other health care personnel who are in training and who, unless specifically requested otherwise, may be present and participate in patient care activities as part of their medical education. There also may be present from time to time a medical product or medical device representative. Consent is hereby given for the presence and participation of such persons as deemed appropriate by the attending physician.

6. Remaining in Patient Care Area and Closed Circuit Monitoring/Videotaping/Photography

Patient acknowledges and understands that, Patient is advised to remain in the patient care area at all times to optimize Patient's medical care and safety. If Patient chooses to leave the area for reasons that are not treatment related, Patient assumes any and all liability for any incident, accident, misadventure or harm, including deterioration of Patient's condition, which Patient may suffer. Patient agrees to hold PHC, all Healthcare Professionals, harmless for any injury or harm resulting from Patient's decision to leave the patient care area and Patient accepts any and all responsibility for such actions. Patient also understands that closed circuit monitoring, videotaping and photography patient care may be used for educational, clinical purposes and/or safety related purposes.

7. Authorization to Release Information

PHC is authorized to release information contained in the patient record. The information authorized to be released shall include, but is not limited to, infectious or contagious disease information, including HIV or AIDS-related evaluations, diagnosis or treatment; information about drug or alcohol abuse or treatment of same and/or psychiatric or psychological information. Patient waives any privilege pertaining to such confidential information. PHC, its agents and employees are hereby released from any and all liabilities, responsibilities, damages, claims and expenses arising from the release of information as authorized above. Reasons for releasing a Patient's record include, but are not limited to, insurance company(s), their agents or other third party payor and/or government or social service agencies which may or will pay for any part of the medical/hospital expenses incurred or authorized by representatives of PHC, as mandated by law, or to alternate care providers, including community agencies and services, as ordered by Patient's physician or as requested by Patient or Patient's family for post-hospital care. **PATIENT ACKNOWLEDGES AND AGREES THAT PATIENT'S RECORDS WILL BE AVAILABLE TO ALL PHC AFFILIATED ENTITIES AND PROVIDERS, AND TO NON-PHC AFFILIATED REFERRING PROVIDERS IN COMPLIANCE WITH THE PROVISIONS OF MEANINGFUL USE.** Patient also agrees, in order for PHC to service accounts or to collect liabilities owed, to receive contact by telephone at any telephone number associated with their record, including wireless telephone numbers, which could result in charges to Patient. PHC or its agents may also contact Patient by sending text messages or emails, using any email address Patient provides. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

8. Patient Survey

Patient authorizes PHC and/or its authorized representative to contact Patient after discharge for the purpose of conducting patient satisfaction surveys and other studies.

9. Patient Rights and Personal Valuables

Patient acknowledges that Patient has received a copy of Patient Rights and has verified the information utilized during this registration and confirms its accuracy. PHC shall not be liable for the loss or damage of any personal belongings, including but not limited to money, cell phones, laptops, electronic devices, jewelry, hearing aids, computers or dentures, unless properly secured and placed within the hospital safe.

10. Consent Timeframe and Applicability

The above consents are applicable to all inpatient and outpatient hospital-based services, as well as all ambulatory and physician office based services. With respect to inpatient hospital based services, including infants delivered and newborn care at any PHC affiliate, the consents shall be valid for a period of 30 days from the date of signature below or for the period of time Patient is confined in the hospital for a particular purpose, whichever is greater. For outpatient-based hospital services, the above consents are valid for a period of 30 days from the date of signature below; provided, however, that if outpatient hospital-based services are provided through serial visits, the above consents will be valid for a term of one (1) year from the date of signature below. For all ambulatory or physician office based services, the above consents are valid for a period of one (1) year from the date of signature below.

Validity of Form

Patient acknowledges that a copy, or an electronic version of this document may be used in place of and is as valid as the original.

Patient understands that the Healthcare Professionals participating in the Patient's care will rely on Patient's documented medical history, as well as other information obtained from Patient, Patient's family or others having knowledge about Patient, in determining whether to perform or recommend the Procedures; therefore, Patient agrees to provide accurate and complete information about Patient's medical history and conditions.

Patient confirms that Patient has read and understood and accepted the terms of this document and the undersigned is the Patient, the Patient's legal representative or is duly authorized by the Patient as the Patient's general agent to execute the above and accept its terms.

Patient/Patient Representative Signature

Patient Name (**PRINT**)

Date

Time

Relationship to Patient

Reason Patient is unable to sign

Piedmont Healthcare Representative Signature

Piedmont Healthcare Representative Name (**PRINT**)

Date

Time

PAST MEDICAL HISTORY

LIST ANY MEDICATION ALLERGIES & THE REACTION:

ALLERGY:	REACTION	ALLERGY:	REACTION:

Other allergies (please check all that apply)

Iodine/Dyes Latex Tape Shellfish

Medications: The clinical Staff member will review with you

Pharmacy/Address/Phone Number

Please list any surgeries or prior hospitalizations:

SURGERIES	YEAR	SURGEON	COMPLICATIONS

Have you ever had MRSA or Staph Infection? If so, please give dates and treatment received.

Please check any previous illnesses that apply:

Anemia High Blood Pressure Diabetes Reflux Asthma Heart Disease Ulcers Seizures
 Cancer Heart Murmur CVA/Stroke Enlarged Prostate Hepatitis B Hepatitis C High Cholesterol
 Thyroid Disease Osteoporosis Kidney Disease Sleep Apnea Osteoarthritis HIV/AIDS COPD
 Depression Rheumatoid Arthritis Other: _____

FAMILY HISTORY

FAMILY MEMBER	ALIVE	DECEASED HEALTH STATUS OR CAUSE OF DEATH
FATHER		
MOTHER		
SIBLING		
SIBLING		
SIBLING		

SOCIAL HISTORY

Current Work Status:

Working: Y N

Disabled: Y N

Medical leave: Y N

Occupation: _____

Reason For Disability: _____

Who took you out of work? _____

Last day of work: _____

Marital Status: ___Single Married ___ Divorced ___ Widowed

Do you have any children: ___ Yes ___ No

Do you use tobacco products? ___ Yes Form of tobacco? _____ Packs/day? _____ How long? _____

No, never _____ No, but I used to _____ Quit Date? _____

Do you drink alcohol? No, never _____ No, but I used to _____ Yes _____

If yes, ___ day ___ weekly ___ Monthly ___ Yearly ___ Occasionally ___ Rarely ___ Socially

Do you currently use illegal drugs? ___ No, ___ yes If yes, please list _____

REVIEW OF SYSTEMS (please check all that apply)

CONSTITUTION

___ Fever ___ Chills ___ Weight Loss
___ Malaise/Fatigue ___ Night sweats
___ Weakness

EYES

___ Blurred Vision ___ Double Vision
___ Photophobia ___ Eye Pain ___ Eye Discharge
___ Eye Redness

GI

___ Bowel Incontinence ___ Constipation
___ Diarrhea ___ Blood in Stool
___ Abdominal Pain
___ Heartburn ___ Nausea ___ Vomiting

SKIN

___ Rash ___ Itching

CARDIOVASCULAR

___ Chest Pain ___ Palpitations

GU

HENT

___ Hearing loss
___ Ringing in ears

___ Orthopnea ___ Dysuria ___ Urgency ___ Frequency

___ Leg Swelling ___ PND ___ Hematuria ___ Flank Pain ___ Bladder Incontinence

___ Ear Pain ___ Ear Discharge

RESPIRATORY

___ Nosebleeds ___ Congestion
___ Sinus
___ Sore Throat

___ Cough ___ Hemoptysis
___ Sputum Production ___ Shortness of breath
___ Wheezing

MUSCULO

___ Myalgias ___ Neck Pain ___ Back Pain
___ Joint Pain ___ Falls

ENDO/HEME/ALLER

___ Easy Bruise/Bleed
___ Env/Allergies
___ Extreme Thirst

NEUROLOGICAL

___ Dizziness ___ Headaches
___ Tingling ___ Tremor
___ Sensory Change ___ Speech Change
___ Focal Weakness ___ Seizures ___ LOC

PSYCHIATRIC

___ Depression ___ Suicidal ideas
___ Substance Abuse ___ Hallucinations
___ Nervous/Anxious
___ Insomnia ___ Memory Loss



Medicare Payer Questionnaire

In order for our staff to determine whether medical services should be covered by Medicare or another insurance, federal law requires the following questions be asked. Thank you for your cooperation.

Name of Patient: _____ Date: _____

Part I	
Are you receiving Black Lung Benefits?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are your services to be paid by a government program such as a research grant?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you entitled to benefits through the Department of Veteran Affairs (DVA)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Was your illness/injury due to a work related accident/condition?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Part II	
Was your illness/injury due to an accident that was not at work?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Part III	
How are you entitled to Medicare?	<input type="checkbox"/> Age <input type="checkbox"/> Disability <input type="checkbox"/> End Stage Renal Disease
If you are entitled by age , are you working?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Never Worked <input type="checkbox"/> N/A
If retired, what is retirement date?	
If yes, are you actively employed by an employer of 20 or more employees?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is your spouse working?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Never Worked <input type="checkbox"/> N/A
If retired, what is your spouse's retirement date?	
If yes, are you actively employed by an employer of 20 or more employees?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If you are entitled by disability , are you employed?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Never Worked
If yes, are you actively employed by an employer of 100 or more employees?	<input type="checkbox"/> Yes <input type="checkbox"/> No