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. As a new patient we ask that you arrive 30 minutes prior to your appointment time to register. As well as bring your insurance card, photo ID, copay, and any medications you may be currently be taking.

- **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 your appointment.

- **Medical Records Release**: If you have records at another Primary healthcare provider’s office we have enclosed a release form. We prefer to have these records on your appointment date, so please submit the request to your Primary Care Provider ASAP. Thank you.

- **Map**: we have provided a map of the Baptist East Hospital Campus to help you find our office along with a picture of the building we are located in.

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

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

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

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

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

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

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

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

If It Is An EMERGENCY Go Directly To The Emergency Room or Call 911!(ex. Loss of limb, eyesight, chest pains, shortness of breath, stroke)
Our Patient Portal
Please sign up for our patient portal. Signing up is simple. Provide us with your updated email address the day of your next scheduled appointment and at mid-night that night you will receive an email link to sign up. You can send messages to us, request refills and receive test results and much more. For questions or concerns regarding the patient portal call 1-877-868-1814.

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

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

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

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

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

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

Form Requests
We charge a $15 or $25 fee for completion of forms. We have a 7-10 day turn-around. The fee depends on the length of the document.
No Shows
It is important that you keep your appointment to provide the best care possible, if you are unable to make your appointment please be sure to call our office at least 24hr prior to cancel your appointment. No shows cause a disruption in the provider's schedule and are considered non-compliant with your care. Not showing up for an appointment can result in dismissal. You may be considered for dismissal if you incur any combination of No shows and/or late cancellations that total three.

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

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

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

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

Nicole Masimasi, M.D. Lead Physician
Maryluz Fuentes, Senior Physician
Preet Kiran, M.D.
Pamela Tuck, M.D.
Audrey Lewis, C.R.N.P.
Zahra Daftarian, C.R.N.P.
JoAnn Matthews-Brown, Practice Manager
We look forward to serving you!

Please visit our website at: http://www.baptistfirst.org/east-montgomery-primary-medicine
# 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.

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<th>Condition</th>
<th>Yourself</th>
<th>Father</th>
<th>Mother</th>
<th>Children</th>
<th>Siblings</th>
<th>Grandmother</th>
<th>Grandfather</th>
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<td>Alcoholism</td>
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<td>Emphysema / COPD</td>
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<td>Epilepsy / Seizures</td>
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<td>Fibromyalgia</td>
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<td>GERD / Acid Reflux</td>
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<td>Heart Disease/Heart Attack</td>
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<td>Hepatitis / Liver Disease</td>
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<td>High Cholesterol</td>
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<td>Stroke</td>
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<td>Sickle Cell Disease</td>
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<td>Sleep Apnea</td>
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**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. ____________________________
2. ____________________________ 5. ____________________________
3. ____________________________ 6. ____________________________

**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. 
2. 
3. 
4. 
5. 
6. 

**SPECIALISTS:**

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

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

- Current / Past Alcohol use
- Chew Tobacco
- Current / Past Drug use
- Regular Exercise
- Single
- Married
- Separated
- Widowed
- Divorced
- Current / Past Smoking
- Caffeine
- Previous Sexually Transmitted Disease
- Sexually Active
- Yes
- No
- Children
- Yes
- No
- How Many?
- Occupation
- Religion

**GYNECOLOGIC HISTORY:** Please complete if you are a female.

- Number of pregnancies
- Number of living children
- Number of miscarriages
- Number of abortions
- Date of last Menstrual period
- Age at first period
- Regular periods every month?
- Yes
- No
- Heavy or Painful periods?
- Yes
- No

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

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

**GENERAL**

- Fever / chills
- Weight gain / loss
- Fatigue
- Poor appetite
- Hot flashes

**ENT/EYES**

- Headaches
- Difficulty hearing
- Difficulty seeing
- Sinus trouble
- Sneezing / Watery-eyes
- Nose bleeds

**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

**SKIN**

- New or Changing Moles
- Spot/Flashes that won’t go away

**HEMATOLOGIC**

- Easy Bruising
- Anemia/Sickle Cell

**IMMUNIZATION AND PREVENTION**

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

**ENDOCRINE**

- Skin/Hair changes
- Thirsty a lot
- Always hot

**PSYCHOLOGICAL**

- Depression
- Anxiety

- Cholesterol test
- Diabetes test
- TB skin test
- Thyroid Test
- Bone Density

**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
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:
Name: East Montgomery Primary Medicine
Address: 470 Taylor Road, Suite 310, Montgomery, AL.36117
Phone: Ph:334.244.4322 Fax:334.244.4321

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 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: __________________________
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 EMPM, to release any information regarding you and your health to:

   - A family member ___Yes ___No
     Names: (please print) __________________ __________________
   1.__________________________________________________________
   2.__________________________________________________________
   - Other Relative ___Yes ___No
     Names: (please print) __________________ __________________
   1.__________________________________________________________
   2.__________________________________________________________
   - Close Personal Friend(s) ___Yes ___No
     Names: (please print) __________________ __________________
   1.__________________________________________________________
   2.__________________________________________________________
   - Personal representative identified by you. If yes, please identify by name:
     1.__________________________________________________________
   - Persons allowed to pick up written prescriptions for you: (caregivers, family members, etc. identification required)
     1.__________________________________________________________
     2.__________________________________________________________
     3.__________________________________________________________

Signature: __________________________ Date: __________________

Please print your name: ________________________________________
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.

________________________________________

________________________________________
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 c/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.
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 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
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: 800-621-5866
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
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