HOPE Family Health

PATIENT REGISTRATION PACKET

PLEASE COMPLETE THE FOLLOWING PAGES IN THIS PACKET IN THEIR ENTIRETY AND AS ACCURATELY AS POSSIBLE

PATIENT INFORMATION (COMPLETE AS ACCURATELY AND CLEARLY AS POSSIBLE)

LAST NAME _____ FIRST NAME _____
STREET ADDRESS _____
CITY _____ STATE _____ ZIP CODE _____
EMAIL ADDRESS _____
HOME PHONE NUMBER _____ DATE OF BIRTH _____
CELL PHONE NUMBER _____ SS# _____
WORK PHONE NUMBER _____ GENDER M☐ F☐
MARITAL STATUS SINGLE☐ MARRIED☐ PARTNER☐ DIVORCED☐ WIDOWED☐
EMPLOYMENT STATUS FULL☐ PART☐ UNEMPLOYED☐ RETIRED☐ OTHER☐
STUDENT STATUS FULL☐ PART☐ NON-STUDENT☐ OTHER☐

RESPONSIBLE PARTY (COMPLETE AS ACCURATELY AND CLEARLY AS POSSIBLE)

☐ PATIENT ☐ SPOUSE ☐ PARENT/GUARDIAN ☐ OTHER

IF OTHER THAN PATIENT PLEASE COMPLETE THE INFORMATION BELOW:

LAST NAME _____ FIRST NAME _____
STREET ADDRESS _____
CITY _____ STATE _____ ZIP CODE _____
HOME PHONE NUMBER _____ DATE OF BIRTH _____
CELL PHONE NUMBER _____ SS# _____
WORK PHONE NUMBER _____

INSURANCE INFORMATION (GIVE COPY OF INSURANCE CARD TO FRONT DESK)

☐ PRIVATELY INSURED ☐ UNINSURED ☐ MEDICARE ☐ TENNCARE

INSURANCE COMPANY _____
SUBSCRIBER'S NAME (POLICY HOLDER) _____
SUBSCRIBER'S SOCIAL SECURITY # _____ SUBSCRIBER'S DATE OF BIRTH _____
SUBSCRIBER'S RELATIONSHIP TO PATIENT _____

SECONDARY INSURANCE COMPANY _____
SUBSCRIBER'S NAME (POLICY HOLDER) _____
SUBSCRIBER'S SOCIAL SECURITY # _____ SUBSCRIBER'S DATE OF BIRTH _____
SUBSCRIBER'S RELATIONSHIP TO PATIENT _____

THE ABOVE INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE. I AUTHORIZE THE PROVIDERS OF HOPE FAMILY HEALTH TO PROVIDE MYSELF AND/OR MY CHILD WITH REASONABLE AND PROPER MEDICAL CARE ACCORDING TO TODAY'S STANDARDS. I AUTHORIZE THE INSURANCE COMPANY OR ANY THIRD PARTY PAYER TO PAY ANY BENEFITS DUE DIRECTLY TO THIS OFFICE SHOULD THEY ACCEPT ASSIGNMENT ON MY CLAIM. I ALSO AUTHORIZE HOPE FAMILY HEALTH OR THE INSURANCE COMPANY TO RELEASE ANY INFORMATION REQUIRED TO PROCESS MY CLAIMS. I UNDERSTAND THAT HOPE FAMILY HEALTH HAS THE RIGHT TO REFUSE OR ACCEPT ASSIGNMENT OF SUCH BENEFITS. IF THESE BENEFITS ARE NOT ASSIGNED TO HOPE FAMILY HEALTH I AGREE TO FORWARD TO THE HEALTH CENTER ALL HEALTH INSURANCE AND OTHER THIRD PARTY PAYMENTS THAT I RECEIVE FOR SERVICES RENDERED TO ME IMMEDIATELY UPON RECEIPT. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR THE ACCOUNT EVEN WHILE INSURANCE MAY BE PENDING ON A PORTION OR ALL OF THE CHARGES.

_____ _____
PATIENT OR GUARDIAN SIGNATURE DATE

EMPLOYER

_____
EMPLOYER NAME
_____
EMPLOYER PHONE NUMBER
_____
OCCUPATION / WORK TITLE

EMERGENCY INFO

_____
EMERGENCY CONTACT
_____
RELATIONSHIP TO PATIENT
_____
PHONE NUMBER

ABOUT YOUR INCOME

YOUR TOTAL HOUSEHOLD ANNUAL INCOME

☐ LESS THAN $1,000
☐ $1,000 TO $2,499
☐ $2,500 TO $4,999
☐ $5,000 TO $9,999
☐ $10,000 TO $24,999
☐ $25,000 TO $49,499
☐ $50,000 TO $99,499
☐ $100,000 TO $249,499
☐ $250,000 TO $499,499
☐ $500,000 TO $999,499
☐ $1,000,000 OR MORE
☐ OTHER/RATHER NOT SAY

ABOUT YOUR HOME

☐ RENT
☐ OWN
☐ LIVE WITH RELATIVES
☐ HOMELESS
☐ OTHER/RATHER NOT SAY

ABOUT YOURSELF

☐ MILITARY VETERAN

ETHNIC GROUP

☐ HISPANIC
☐ NON/HISPANIC

RACE

☐ ASIAN
☐ NATIVE HAWAIIAN
☐ OTHER/PACIFIC ISLANDER
☐ BLACK/AFRICAN AMERICAN
☐ AMERICAN INDIAN/ALASKA
☐ WHITE
☐ MORE THAN ONE RACE
☐ OTHER/RATHER NOT SAY

PRIMARY LANGUAGE

☐ ENGLISH
☐ SPANISH
☐ OTHER

LAST NAME _____ FIRST NAME _____ DATE OF BIRTH _____

CURRENT MEDICATIONS (PLEASE BRING ALL CURRENT MEDICATION BOTTLES WITH YOU)

NAME OF MEDICATION	STRENGTH (MG)	FREQUENCY (EX: ONE A DAY)

MEDICAL HISTORY (CHECK ALL THAT APPLY BOTH PRESENT OR IN THE PAST)

CONDITION	BRIEF EXPLANATION OR ONSET DATE AND TREATMENT RECEIVED
DIABETES	
HIGH BLOOD PRESSURE	
HIGH CHOLESTEROL	
HEART ATTACK/DISEASE	
BLOOD CLOT	
STROKE	
KIDNEY DISEASE	
MENTAL ILLNESS	
ASTHMA	
COPD (LUNG DISEASE)	
CANCER	
ABNORMAL PAP (FEMALE ISSUES)	
HIV POSITIVE	
OTHER	
OTHER	
OTHER	

ALLERGIES (MEDICINE ALLERGIES, FOOD ALLERGIES, ETC.)

ALLERGY	BRIEF EXPLANATION OF REACTION

LAST NAME _____ FIRST NAME _____ DATE OF BIRTH _____

FAMILY MEDICAL HISTORY (BLOOD RELATED CHILDREN/PARENTS/SIBLINGS/GRANDPARENTS ON BOTH SIDES)

RELATIONSHIP	CONDITION	RELATIONSHIP	CONDITION	RELATIONSHIP	CONDITION
_____	DIABETES	_____	KIDNEY DISEASE	_____	_____
_____	HIGH BLOOD PRESSURE	_____	MENTAL ILLNESS	_____	_____
_____	HIGH CHOLESTEROL	_____	ASTHMA	_____	_____
_____	HEART ATTACK/DISEASE	_____	COPD (LUNG DISEASE)	_____	_____
_____	BLOOD CLOT	_____	CANCER	_____	_____
_____	STROKE	_____	ABNORMAL PAP (FEMALE ISSUES)	_____	_____

SOCIAL HISTORY (PLEASE COMPLETE THIS SECTION FULLY AND HONESTLY - ANSWERS ARE CONFIDENTIAL)

DO YOU DRINK ALCOHOL YES ☐ NO ☐ # OF DRINKS PER WEEK _____ DO YOU SMOKE YES ☐ NO ☐ PACKS PER DAY _____

DO YOU CONSUME CAFFEINE YES ☐ NO ☐ # OF DRINKS PER WEEK _____ DO YOU EXERCISE REGULARLY? YES ☐ NO ☐

DO YOU USE RECREATIONAL DRUGS YES ☐ NO ☐ WHICH DRUGS DO YOU USE? _____

HOSPITALIZATIONS AND SURGERIES (CHECK ALL THAT APPLY SINCE BIRTH)

CONDITION	BRIEF EXPLANATION OR ONSET DATE AND TREATMENT RECEIVED
HYSTERECTOMY	_____
TONSIL REMOVAL	_____
GALL BLADDER REMOVAL	_____
ORTHOPEDIC SURGERIES	_____
BYPASS SURGERIES	_____
COSMETIC SURGERIES (LIST ALL)	_____
LASIC/EYE SURGERIES	_____
CESAREAN DELIVERIES	_____
VASECTOMY/TUBAL	_____
OTHER SURGERY/HOSPITALIZATION	_____
OTHER SURGERY/HOSPITALIZATION	_____
OTHER SURGERY/HOSPITALIZATION	_____

HEALTH SCREENING / PREVENTATIVE (PLEASE INCLUDE THE DATE LAST PERFORMED)

	DATE LAST PERFORMED		DATE LAST PERFORMED
ROUTINE PHYSICAL	_____	FLU SHOT	_____
MAMMOGRAM	_____	TETANUS SHOT	_____
PSA	_____	SHINGLES VACCINE	_____
BONE DENSITY	_____	HEPATITIS VACCINE	_____
CHEST X-RAY	_____	OTHER VACCINES	_____
EKG	_____	CHOLESTEROL SCREENING	_____
PNEUMONIA SHOT	_____	DIABETES SCREENING	_____
*PAP	_____	who performed your PAP:	_____
*COLONOSCOPY	_____	who performed your colonoscopy:	_____

LAST NAME _____ FIRST NAME _____ DATE OF BIRTH _____

HOPE
Family Health

COMMUNICATING WITH ME AND LOVED ONES

I AUTHORIZE HOPE TO COMMUNICATE WITH ME ABOUT MY HEALTH

BY SIGNING BELOW I AGREE TO ALLOW HOPE FAMILY HEALTH TO COMMUNICATE WITH ME IN PERSON, PHONE, VOICE MESSAGE, EMAIL, DIRECT MAIL AND/OR TEXT MESSAGE WHENEVER AND USING WHICHEVER METHOD IS APPLICABLE, APPROPRIATE AND AVAILABLE.

I FORBID HOPE FROM COMMUNICATING WITH ME USING THE FOLLOWING METHOD(S)

_____

_____ _____

PATIENT OR GUARDIAN SIGNATURE DATE

I AUTHORIZE HOPE TO COMMUNICATE WITH LOVED ONES ABOUT MY HEALTH

BY SIGNING BELOW I AUTHORIZE HOPE FAMILY HEALTH TO DISCUSS MY MEDICAL CARE, HEALTH HISTORY, DIAGNOSIS INFORMATION AND TREATMENT OPTIONS WITH THE FOLLOWING INDIVIDUALS:

_____ _____

_____ _____

_____ _____

PATIENT OR GUARDIAN SIGNATURE DATE

LAST NAME _____ FIRST NAME _____ DATE OF BIRTH _____

HOPE Family Health

RELEASING MY INFORMATION FOR A SPECIAL PROGRAM(S)

THIS PAGE IS OPTIONAL & MAY NOT APPLY TO ANY PROGRAM YOU WILL PARTICIPATE IN AS A PATIENT AT HOPE

TO PHARMACEUTICAL COMPANIES

HOPE FAMILY HEALTH OFFERS PATIENT ASSISTANCE PROGRAMS TO HELP PATIENTS WHO QUALIFY OBTAIN CERTAIN MEDICINES AT EITHER A DISCOUNTED PRICE OR NO COST AT ALL. IN ORDER TO DETERMINE YOUR ELIGIBILITY FOR THE PROGRAM AND TO ADMINISTER YOUR PARTICIPATION IN THE PROGRAM IF YOU ARE ACCEPTED, HOPE ALONG WITH AFFILIATED PHARMACEUTICAL COMPANIES AS WELL AS THEIR AFFILIATES AND CONTRACTORS NEED TO OBTAIN CERTAIN INFORMATION ABOUT YOU.

BY SIGNING BELOW I REQUEST AND AUTHORIZE MY HEALTH CARE PROVIDER AND HEALTH CARE TEAM AT HOPE FAMILY HEALTH TO GIVE AFFILIATED PHARMACEUTICAL COMPANIES AS WELL AS THEIR AFFILIATES AND CONTRACTORS INFORMATION ABOUT ME AND MY MEDICAL CONDITION, WHICH IS NECESSARY TO DETERMINE MY ELIGIBILITY FOR THE ASSISTANCE PROGRAM AND FOR MY CONTINUING PARTICIPATION IN THE PROGRAM IF I AM ACCEPTED AND TO ADMINISTER THE PROGRAM, TO ACCOUNT FOR MY WITHDRAWAL IF I DECIDE TO STOP PARTICIPATING IN THIS PROGRAM, AND TO EVALUATE PATIENT SATISFACTION AND THE PROGRAMS OVERALL EFFECTIVENESS. THE TYPE OF INFORMATION THAT CAN BE GIVEN UNDER THIS AUTHORIZATION MAY INCLUDE MY NAME, BIRTH DATE, ADDRESS, TELEPHONE NUMBER, MY SOCIAL SECURITY NUMBER, FINANCIAL INFORMATION, INFORMATION ABOUT MY HEALTH BENEFITS AND OR INSURANCE COVERAGE, INFORMATION ABOUT MY MEDICAL CONDITION(S).

I KNOW THAT I CAN CANCEL THIS AUTHORIZATION AT ANY TIME BY WRITING TO HOPE FAMILY HEALTH AT 12124 HWY 52 WEST, WESTMORELAND TENNESSEE 37186. IF I CANCEL THIS AUTHORIZATION THEN HOPE FAMILY HEALTH WILL STOP PROVIDING THESE AFFILIATES AND THEIR CONTRACTORS INFORMATION ABOUT ME HOWEVER I CANNOT CANCEL ACTIONS THAT HAVE ALREADY BEEN TAKEN WITH THIS AUTHORIZATION PRIOR TO MY CANCELLATION. I UNDERSTAND THAT ONCE HOPE FAMILY HEALTH GIVES PHARMACEUTICAL COMPANIES AS WELL AS THEIR AFFILIATES AND CONTRACTORS INFORMATION ABOUT ME BASED ON THIS AUTHORIZATION ,FEDERAL PRIVACY LAWS MAY NOT PREVENT HOPE FAMILY HEALTH ALONG WITH AFFILIATED PHARMACEUTICAL COMPANIES AS WELL AS THEIR AFFILIATES AND CONTRACTORS FROM FURTHER DISCLOSING MY INFORMATION.

I UNDERSTAND THAT SIGNING THIS AUTHORIZATION DOES NOT GUARANTEE I WILL BE ACCEPTED INTO THE PROGRAM.

_____ _____

PATIENT OR GUARDIAN SIGNATURE DATE

FOR INSURANCE ENROLLMENT ASSISTANCE

HOPE FAMILY HEALTH AND ITS AFFILIATES REGULARLY WORKS WITH INSURANCE COMPANIES AND THE HEALTH INSURANCE MARKETPLACE FOR PURPOSES OF BILLING AND/OR ENROLLMENT. BY SIGNING BELOW I REQUEST AND AUTHORIZE MY HEALTH CARE PROVIDER AND HEALTH CARE TEAM AT HOPE FAMILY HEALTH TO GIVE INFORMATION ABOUT ME WHEN AND IF IT IS NECESSARY. THE TYPE OF INFORMATION THAT CAN BE GIVEN UNDER THIS AUTHORIZATION MAY INCLUDE MY NAME, BIRTH DATE, ADDRESS, TELEPHONE NUMBER, MY SOCIAL SECURITY NUMBER, FINANCIAL INFORMATION, INFORMATION ABOUT MY HEALTH BENEFITS AND OR INSURANCE COVERAGE, AND INFORMATION ABOUT MY MEDICAL CONDITION(S).

_____ _____

PATIENT OR GUARDIAN SIGNATURE DATE

LAST NAME _____ FIRST NAME _____ DATE OF BIRTH _____

HOPE Family Health

REQUESTING & RELEASING MY HEALTH INFORMATION

"PHI" STANDS FOR "PROTECTED HEALTH INFORMATION" & USUALLY WILL CONTAIN PORTIONS OR ALL OF YOUR PAPER OR ELECTRONIC HEALTH RECORD

HOPE MAY RELEASE MY PHI TO OTHER HEALTH CARE PROVIDERS

I HEREBY AUTHORIZE HOPE FAMILY HEALTH AND ITS PHYSICIANS, MID-LEVEL PROVIDERS, EMPLOYEES, AND AGENTS TO RELEASE OR DISCLOSE MY PROTECTED HEALTH INFORMATION INCLUDING MEDICAL RECORDS AND RECORDS PERTAINING TO TREATMENT, PROGNOSIS AND DIAGNOSIS, INCLUDING ANY SPECIALLY PROTECTED OR LISTED RECORDS, SUCH AS THOSE RELATED TO PSYCHOLOGICAL AND/OR PSYCHIATRIC IMPAIRMENTS, DRUG ABUSE, ALCOHOLISM, HIV, OR ANY OTHER CONDITION OR DIAGNOSIS. LIST BELOW ANY/ALL HEALTH CARE PROVIDERS/ATTORNEYS/REHAB FACILITIES/SPECIALISTS, ETC. THAT YOU WISH FOR HOPE FAMILY HEALTH TO RELASE YOUR INFORMATION/RECORDS TO:

_____ _____

_____ _____

THIS BOX IS FOR INTERNAL USE ONLY. HOPE STAFF MAY USE THIS BOX TO UPDATE OR ADD THE CONTACT INFORMATION OF A HEALTH CARE PROVIDER THAT YOU AUTHORIZE US TO RELEASE OR REQUEST YOUR HEALTH INFORMATION FROM THAT IS NOT ALREADY LISTED ON THIS PAGE. IN THE EVENT THIS BOX IS USED FOR THAT PURPOSE A NEW COPY WILL BE SCANNED INTO YOUR ELECTRONIC HEALTH RECORD AS REQUIRED BY HOPE POLICY AND WILL BE MADE AVAILABLE TO YOU.

HOPE MAY REQUEST MY PHI FROM OTHER HEALTH CARE PROVIDERS

I authorize and request the disclosure of all protected information to HOPE Family Health for the purpose of review and evaluation as it pertains to my health and medical diagnosis, prevention and treatment. I expressly request that the designated record custodian of all covered entities under HIPAA identified above disclose full and complete protected medical information including the following: (please check all that you wish to release) All medical records, meaning every page in my record, including but not limited to: office notes, face sheets, history and physical, consultation notes, inpatient, outpatient and emergency room treatment, all clinical charts, reports, order sheets, progress notes, nurse's notes, social worker records, clinic records, treatment plans, admission records, discharge summaries, requests for and reports of consultations, documents, correspondence, test results, statements, questionnaires/histories, inpatient, outpatient and emergency room treatment, all clinical charts, reports, order sheets, progress notes, nurse's notes, social worker records, clinic records, treatment correspondence, photographs, videotapes, telephone messages, and records received by other medical providers. Any facsimile, copy or photocopy of the authorization shall authorize you to release the records requested herein. This authorization shall be in force and effect until two years from date of execution at which time this authorization expires.

- All physical, occupational and rehabilitation requests, consultations and progress notes.
- All disability, Medicaid or Medicare records including claim forms and record of denial of benefits.
- All employment, personnel or wage records.
- All autopsy, laboratory, histology, cytology, pathology, immunohistochemistry records and specimens; radiology records and films including
- CT scan, MRI, MRA, EMG, bone scan, myleogram; nerve conduction study, echocardiogram and cardiac catheterization results, videos/CDs/films/reels and reports.
- All pharmacy/prescription records including NDC numbers and drug information handouts/monographs.
- All billing records including all statements, insurance claim forms, itemized bills, and records of billing to third party payers and payment or denial of benefits.

I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human of this type of information. This authorization is given in compliance with the federal consent requirements for release of alcohol or substance abuse records of 42 CFR 2.31, the restrictions of which have been specifically considered and expressly waived. I understand the following: See CFR §164.508(c)(2)(i-iii) A. I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization. B. The information released in response to this authorization may be re-disclosed to other parties. C. My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.

LIST ALL PROVIDERS, PHYSICIANS, OFFICES, HOSPITALS, TREATMENT CENTERS OR OTHER MEDICAL FACILITIES YOU HAVE VISITED IN THE PAST 5 YEARS

_____ _____ _____

_____ _____ _____

RELEASE RECORDS MENTIONED HEREIN TO: HOPE Family Health (USING SECURED EMAIL OR FAX AS PREFERRED METHOD):
12124 Hwy 52 W | Westmoreland | TN | 37186 | phone: 615-644-2000 | fax: 615-644-2078 | email: info@hopefamilyhealth.org

_____ _____

PATIENT OR GUARDIAN SIGNATURE DATE

HIPAA PRIVACY LAWS AND HEALTH CENTER PRIVACY POLICY/CONSENT | PAGE 1

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirement officially began on April 14, 2003. Many of the policies have been our practice for years. This is an abbreviated version, however the complete text is available in our offices or on the U.S. Department of Health and Human Services web site: www.hhs.gov.

HIPAA states that there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office medical services.

Your information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers if desired, laboratories and health insurance payers as is necessary and appropriate for your care.

Our Electronic Medical Record (EMR) is secure and personal information is encrypted to insure confidentiality. General information which does not include any client identifiers may be used in retrospective studies. However, studies requiring any personal identifiers will require your approval and consent.

It is the policy of this office to remind clients of their appointment. We may do this by telephone, text, e-mail, U.S. mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

We agree to provide clients with access to their records in accordance with state and federal laws. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

We may change, add, delete or modify any of these provisions to better serve the needs of the practice and the client. You have the right to request restrictions in the use of your protected health information as the law permits. Your confidential information will not be sold for any reason.

Your signature will indicate that you have read the HIPAA information and the information herein this document and consent to the guidelines set forth in the Act as well as policies and procedures established at HOPE Family Health regarding your privacy and health information.

NOTICE OF HEALTHCARE PRIVACY PRACTICES AT HOPE Family Health

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please read it carefully.

I. We Have A Legal Duty To Safeguard Your Protected Health Information (PHI)

We are legally required to protect the privacy of health information that may reveal your identity. This information is commonly referred to as "protected health information," or "PHI" for short. It includes information that can be used to identify you that we have created or received about your past, present or future health or condition, the provision of health care to you, or the payment of this health care. We must provide you with this notice about our privacy practices that explains how, when and why we use and disclose your PHI.

With some exceptions, we may not use or disclose any more of your PHI than is necessary to accomplish the purpose of the use or disclosure. We are legally required to follow the privacy practices that are described in this notice.

We reserve the right to change the terms of this notice and our privacy policies at any time. Any changes will apply to the PHI we already have. Before we make an important change to our policies, we will promptly change this notice and post a new notice. You can also request a copy of this notice at any time from the contact person listed in Section VI below, by calling our office.

II. How We May Use And Disclose Your Protected Health Information
We use and disclose health information for many different reasons. For some of these uses or disclosures, we need your prior consent or specific authorization. Below we describe the different categories of our uses and disclosures and give you some examples of each category.

During your intake, prior to receiving any health care services, you will be asked to sign a statement permitting HOPE Family Health and its medical staff to release your health information for purposes of Treatment, Payment and Health Care Operations. A description of each of these uses is described as follows.
A. Uses and Disclosures Relating to Treatment, Payment or Health Care Operations.

We may use and disclose your PHI for the following reasons:
1.For treatment. We may disclose your PHI to physicians, nurses, medical students, and other health care personnel who provide you with health care services or are involved in your care.
2.To obtain payment for treatment. We may use and disclose your PHI in order to bill and collect payment for the treatment and services provided to you. For example, we may provide portions of your PHI to our billing department and your health plan to get paid for the health care services we provided to you. We may also provide your PHI to our business associates, such as billing companies, claims processing companies and others that process our health care claims or provide services on our behalf, or provide services directly to you.

PLEASE ASK A MEMBER OF OUR FRONT DESK TEAM TO MAKE A COPY OF THIS SECTION FOR YOUR RECORDS

3. For health care operations. We may disclose your PHI in order to operate our health care delivery system. For example, we may use your PHI in order to evaluate the quality of health care services that you received or to evaluate the performance of the health care professionals who provided health care services to you. We may also provide your PHI to our accountants, attorneys, consultants and other in order to make sure we're complying with the laws that affect us.

To the extent we are required to disclose your PHI to contractors, agents and other business associates who need the information in order to assist us with obtaining payment or carrying our out business operations, we will have a written contract to ensure that our business associate also protects the privacy of your PHI.

B. Other Uses And Disclosures That Do Not Require Your Consent.

We may use and disclose your PHI without your consent or authorization for the following reasons:
1.When a disclosure is required by federal, state or local law, judicial or administrative proceedings or law enforcement. For example, we make disclosures when a law requires that we report information to government agencies and law enforcement personnel about victims of abuse, neglect or domestic violence; when dealing with gunshot and other wounds; or when ordered in a judicial or administrative proceeding.
2.For public health activities. For example, we report information about births, deaths and various diseases to governmental official in charge of collecting that information.
3.Victims of Abuse, Neglect or Domestic Violence. We may release your PHI to a public health authority that is authorized to receive reports of abuse, neglect or domestic violence. For example, we may report your information to government officials if we reasonably believe that you have been a victim of abuse, neglect or domestic violence. We will may every effort to obtain your permission before releasing this information, but in some cases we may be required or authorized to act without your permission.
4.For health oversight activities. For example, we will provide information to assist the government when it conducts an investigation or inspection of a health care provider or organization.
5.Emergency Situations. We may use or disclose your PHI if you need emergency treatment, but we are unable to obtain your consent. If this happens, we will try to obtain your consent as soon as we reasonably can after we treat you.
6.Communication Barriers. We may use or disclose your PHI if we are unable to obtain your consent because of substantial communication barriers, and we believe you would want us to treat you if we could communicate with you.
7.Product Monitoring, Repair and Recall. We may disclose your information to a person or company that is required by the Food and Drug Administration to: (1) report or track product defects or problems; (2) repair, replace or recall defective or dangerous products; or (3) monitor the performance of a product after it has been approved for use by the general public.
8.Lawsuits and Disputes. We may disclose your PHI if we are ordered to do so by a court or administrative tribunal that is handling a lawsuit or other dispute.
9.Law Enforcement. We may disclose your PHI to law enforcement officials for any of the following reasons:
1.To comply with court orders or laws that we are required to follow;
2.To assist law enforcement officers with identifying or locating a suspect, fugitive, witness or missing person;
3.If you have been the victim of a crime and we determine that: (1) we have been unable to obtain your consent because of any emergency or your incapacity; (2) law enforcement officials need the information immediately to carry out their law enforcement duties; and (3) in our professional judgment disclosure to these officers is in your best interests;
4.If we suspect a patient's death resulted from criminal conduct;
5.If necessary to report a crime that occurred on our property; or
6.If necessary to report a crime discovered during an offsite medical emergency (for example, by emergency medical technicians at the scene of a crime).

10.Military and Veterans. If you are in the Armed Forces, we may disclose your PHI to appropriate military command authorities for activities they deem necessary to carry out their military mission. We may also release health information about foreign military personnel to the appropriate foreign military authority.
11.Inmates and Correctional Institutions. If you are an inmate or you are detained by a law enforcement officer, we may disclose your PHI to the prison officers or law enforcement officers if necessary to provide you with health care, or to maintain safety, security and good order at the place where you are confined. This includes sharing information that is necessary to protect the health and safety of other inmates or persons involved in supervising or transporting inmates.
12.Coroners, Medical Examiners and Funeral Directors. In the unfortunate event of your death, we may disclose your PHI to a coroner or medical examiner. This may be necessary, for example, to determine the cause of death. We may also release this information to funeral directors as necessary to carry out their duties.
13.For purposes of organ donation. We may notify organ procurement organizations to assist them in organ, eye or tissue donation and transplants.
14.For research purposes. In most cases, we will ask for your written authorization before using your PHI for research purposes. However, in certain, limited, circumstances, we may use and disclose your PHI without consent or authorization if we obtain approval through a special process to ensure that such research poses little risk to your privacy. In any case, we would never allow researchers to use your name or identity publicly. We may also release your health information without your written authorization to people who are preparing for a future research project, so long as no personally identifiable information leaves our facility.
15.To avoid harm. In order to avoid a serious threat to the health or safety of a person or the public, we may provide PHI to law enforcement personnel or persons able to prevent or lessen such harm.
16.For specific government functions. We may disclose PHI of military personnel and veterans in certain situations. And we may disclose PHI for national security purposes, such as protecting the president of the United States or conducting intelligence operations.
17.For workers' compensation purposes. We may provide PHI in order to comply with workers' compensation laws.

18.Appointment reminders and health-related benefits or services. We may use PHI to provide appointment reminders or give you information about treatment alternatives or other health care services or benefits we offer and/or provide.
19.De-identified Information. We may also disclosure your PHI if it has been de-identified or unable for anyone to connect back to you. This might occur if you are participating in a research project.
20.Incidental Disclosures. While we will take reasonable steps to safeguard the privacy of your PHI, certain disclosures of your PHI may occur during, or as an unavoidable result of our otherwise permissible uses or disclosures of your health information. For example, during the course of a treatment session, other patients in the treatment area may see, or overhear discussion of, your PHI.

C. Uses and Disclosures Require Your Prior Written Authorization.

In any situation, we will ask for your written authorization before using or disclosing any of your PHI. If you choose to sign an authorization to disclose your PHI, you can later revoke that authorization in writing to stop any future uses and disclosures (to the extent that we have not taken any actions relying on the authorization).

III. What Rights You Have Regarding Your PHI

You have the following rights with respect to your PHI:
A. The Right to Request Limits on Uses and Disclosures of Your PHI.

You have the right to ask that we limit how we use and disclose your PHI. We will consider your request, but are not legally required to accept it. If we accept your request, we will put any limits in writing and abide by them except in emergency situations. You may not limit the uses and disclosures that we are legally required or allowed to make.

B. The Right to Choose How We Send PHI to You.

You have the right to ask that we send information to you to an alternate address or by alternate means. We must agree to your request so long as we can easily provide it to the location and in the format you request.

C. The Right to See and Get Copies of Your PHI.

In most cases, you have the right to look at or get copies of your PHI that we have, but you must make the request in writing. If we don't have your PHI but we know who does, we will tell you how to get it. We will respond to you within 10 days after receiving your written request. In certain situations, we may deny your request. If we do, we will tell you, in writing, our reasons for the denial and explain your right to have the denial reviewed.

If you request copies of your PHI, we may charge you a fee for each page. We will respond to your request within 30 days after receiving your written request. Instead of providing the PHI you requested, we may provide you with a summary or explanation of the PHI as long as you agree to that and to the associated cost in advance.

D. The Right to Get a List of the Disclosures We Have Made.

You have the right to get a list of instances in which we have disclosed your PHI. The list will not include uses or disclosures that you have already been informed of, such as those made for treatment, payment or health care operations, directly to you, to your family, or in our facility directory. The list also won't include uses and disclosures made for national security purposes, to corrections or law enforcement personnel.

Your request must state a time period for the disclosures you want us to include. We will respond within 60 days of receiving your request. The list we will give you will include disclosures made in the last six years (with the oldest date being September 1, 2009) unless you request a shorter time. The list will include the date of the disclosure, to whom PHI was disclosed (including their address, if known), a description of the information disclosed and the reason for the disclosure. We will provide the list to you at no charge, but if you make more than one request in the same calendar year, we will charge you for each additional request.

E. The Right to Correct or Update Your PHI.

If you believe that there is a mistake in your PHI or that a piece of important information is missing, you have the right to request that we correct the existing information or add the missing information. You must provide the request and your reason for the request in writing. We will respond within 60 days of receiving your request. We may deny your request in writing if the PHI is (I) correct and complete, (ii) not created by us, (iii) not allowed to be disclosed, or (iv) not part of our records. Our written denial will state the reasons for the denial and explain your right to file a written statement of disagreement with the denial. If you don't file one, you have the right to request that your request and our denial be attached to all future disclosures of you PHI. If we approve your request, we will make the change to your PHI, tell you that we have done it and tell others that need to know about the change to your PHI.

F. The Right to Get This Notice by E-Mail.

You have the right to get a copy of this notice by e-mail. Even if you have agreed to receive notice via e-mail, you also have the right to request a paper copy of this notice.

How To Complain About Our Privacy Practices
If you think we may have violated your privacy rights, or you disagree with a decision we made about access to your PHI, you may file a complaint with the person listed in Section V below. We will take no retaliatory action against you if you file a complaint about our privacy practices. You also may send a written complaint to the Secretary of the Department of Health and Human Services at:

US Department of HHS Government Center
John F. Kennedy Federal Building- Room 1875
Boston, Massachusetts 02203

Telephone number: 617-565-1340 Fax number: 617-565-3809 TDD: 617-565-1343

IV. Person To Contact For Information About This Notice Or To Complain About Our Privacy Practices or for Information Regarding Our Privacy and Information Security

If you have any questions about this notice or any complaints about our privacy practices, or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, please contact us:

HOPE Family Health
12124 Hwy 52 W
Westmoreland TN 37186

Telephone number: 615-644-2000 Fax Number: 615-644-2078 E-mail: info@hopefamilyhealth.org

V. Effective Date Of This Notice | January 1 2011 | Revised/Updated June 1 2013

HOPE Family Health

ACKNOWLEDGMENT AND UNDERSTANDING OF HIPAA PRIVACY LAWS AND POLICIES

I HAVE HAD THE OPPORTUNITY TO REVIEW A COPY OF THE PRIVACY (HIPAA) LAWS AND HEALTH CENTER PRIVACY POLICY AND TO ASK ANY QUESTIONS I MIGHT HAVE ABOUT THEM. I CONSENT TO THE REGULATIONS OF THESE LAWS AND (HIPAA) AND PRIVACY POLICES OF HOPE FAMILY HEALTH. YOU MAY REFUSE TO REVIEW OR CONSENT TO THESE POLICIES AND LAWS HOWEVER YOU MUST DO SO IN WRITING.

PATIENT OR GUARDIAN SIGNATURE DATE

PLEASE ASK A MEMBER OF OUR FRONT DESK TEAM TO MAKE A COPY OF THIS SECTION FOR YOUR RECORDS