Piedmont HEALTHCARE

Patient Registration Form

PATIENT INFORMATION

Full legal name (First, Middle, Last, suffix) _____ Nickname _____ Sex: ❑ Male ❑ Female

Date of birth _____ Social security number _____ Race _____ Preferred language _____

Ethnicity: ❑ Hispanic ❑ Non-Hispanic Marital status: ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed ❑ Life partner

Complete mailing address: _____
(Street, city, state, zip code, county)

Home phone number: _____ Cell phone number: _____ Work number: _____

Email: _____

Employment status: ❑ Full-time ❑ Part-time ❑ Active duty ❑ Self-employed ❑ Not employed ❑ 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: ❑ Self ❑ Spouse ❑ Mother ❑ Father ❑ Legal guardian ❑ Other: _____ Sex: ❑ Male ❑ Female

Home phone number: _____ Cell phone number: _____ Work number: _____

Complete mailing address – if different from patient: _____
(Street, city, state, zip code, county)

Employment status: ❑ Full-time ❑ Part-time ❑ Active duty ❑ Self-employed ❑ Not employed ❑ Retirement date: _____

Employer name: _____ Employer phone number: _____

Employer complete address: _____
(Street, city, state, zip code)

EMERGENCY CONTACT INFORMATION

Name (First, Last): _____

Relation to patient: ❑ Spouse ❑ Mother ❑ Father ❑ Legal guardian ❑ 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: ❑ Self ❑ Spouse ❑ Child ❑ Other: _____

Secondary insurance: _____ Patient relation to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ 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: ❑ Full-time ❑ Part-time ❑ Active duty ❑ Self-employed ❑ Not employed ❑ Retirement date: _____

Employer name: _____ Employer size: ❑ 0 – 19 employees ❑ 20 – 99 ❑ 100+

Employer complete address: _____
(Street, city, state, zip code)

Primary care physician:	Do you want anyone to know you are here? ❑ Yes or ❑ No

DO NOT SCAN

Piedmont HEALTHCARE

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.

Piedmont HEALTHCARE

ACKNOWLEDGMENT OF RECEIPT OF "NOTICE OF PRIVACY PRACTICES"

Patient Label

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:

_____

_____

Piedmont HEALTHCARE

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

Piedmont HEALTHCARE

Conditions of Service and Consent for Treatment

Patient Label

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

Piedmont HEALTHCARE

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

ATLANTA
BRAIN AND SPINE CARE
Expert Care. Human Touch.

REFERRING PHYSICIAN INFORMATION SHEET

Please complete the following information on every provider that has treated you for the condition you are being treated for today:

Physician Name:_____ Phone #: _____
Address:_____ Dates Treated:_____
_____ Specialty:_____
_____ Office use: NPI #: _____

Physician Name:_____ Phone #: _____
Address:_____ Dates Treated:_____
_____ Specialty:_____
_____ Office use: NPI #: _____

Physician Name:_____ Phone #: _____
Address:_____ Dates Treated:_____
_____ Specialty:_____
_____ Office use: NPI #: _____

Physician Name:_____ Phone #: _____
Address:_____ Dates Treated:_____
_____ Specialty:_____
_____ Office use: NPI #: _____

Physician Name:_____ Phone #: _____
Address:_____ Dates Treated:_____
_____ Specialty:_____
_____ Office use: NPI #: _____

ATLANTA
BRAIN AND SPINE CARE
Expert Care. Human Touch.

Narcotics – Medication Policy

EACH PATIENT HAS SPECIFIC REQUIREMENTS FOR TREATMENT. WE WILL EVALUATE EACH PATIENT AND DETERMINE THE BEST METHOD OF TREATMENT TO INCLUDE PHYSICAL THERAPY, INJECTION THERAPY AND MEDICATIONS. TO PROVIDE THE BEST CARE IN THE MOST EFFICIENT AND TIMELY MANNER, WE ASK ALL OF OUR PATIENTS TO READ AND SIGN THE FOLLOWING CONTRACT. **After reading each item below, please place your initials by the following eight (8) items.**

_____1. NARCOTIC/SEDATIVE MEDICATIONS ***WILL NOT BE CALLED IN AFTER 5PM.***

_____2. NARCOTIC/SEDATIVE MEDICATIONS ***WILL NOT BE CALLED IN OVER THE WEEKEND.***

_____3. REFILLS WILL NOT BE GIVEN TO PATIENTS THAT HAVE NOT BEEN SEEN RECENTLY. THIS WILL BE DETERMINED BY THE PHYSICIAN.

_____4. REFILLS WILL NOT BE GIVEN FOR LOST OR STOLEN PRESCRIPTIONS OF NARCOTICS OR SEDATIVES.

_____5. REQUESTS FOR MEDICATIONS MADE ***AFTER NOON ON FRIDAY WILL NOT BE CALLED IN UNTIL MONDAY.***

_____6. WHEN CALLING FOR A MEDICATION LEAVE THE PHARMACY NAME AND NUMBER AS WELL AS YOUR NUMBER. IF YOU HAVE CHANGED THE MEDICATIONS YOU ARE TAKING, WE NEED TO KNOW THOSE CHANGES.

_____7. ONLY ONE PHYSICIAN SHOULD BE PRESCRIBING YOUR MEDICATIONS.

_____8. MOST IMPORTANTLY: DO NOT WAIT UNTIL THE LAST MINUTE TO REQUEST MEDICATIONS. MEDICATIONS WILL BE CALLED IN AS QUICKLY AS POSSIBLE, BUT YOU SHOULD EXPECT A ***24 TO 48 HOUR PERIOD OF TIME BEFORE YOUR MEDICATION IS CALLED IN TO YOUR PHARMACY. IT IS YOUR RESPONSIBILITY TO KEEP UP WITH YOUR MEDS. DO NOT WAIT UNTIL YOU RUN OUT TO CALL FOR MEDICATIONS.***

I UNDERSTAND THE ABOVE STATEMENTS AND AGREE TO FOLLOW THEM AS STATED.

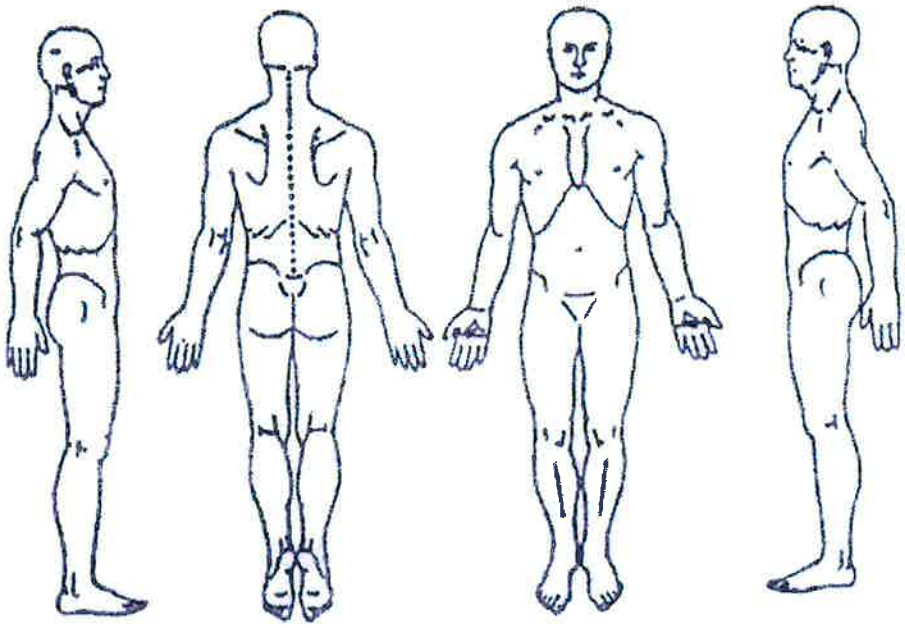
SIGNATURE_____DATE_____

Piedmont PHYSICIANS

Pain Questionnaire

Name:_____

Please Indicate pain with **X**'s and Numbness with O's on diagram below:



When did your symptoms start? _____

Describe your pain:	**What aggravates your pain:**	**What improves your pain:**	**What treatments have you tried:**
Aching ☐	Bending ☐	Nothing ☐	Nothing ☐
Dull ☐	Twisting ☐	Ice ☐	Physical Therapy ☐
Sharp ☐	Lifting ☐	Heat ☐	Massage Therapy ☐
Shooting ☐	Sitting ☐	Sitting ☐	Chiropractic ☐
Stabbing ☐	Standing ☐	Lying down ☐	Name of Chiropractor:
Burning ☐	Walking ☐	Stretching ☐	
Stiffness ☐	Running ☐	Changing positions ☐	Pain Management Injections ☐
Other:	Coughing/Sneezing ☐	Exercise ☐	Name of Pain Management Doctor:
	Lying flat ☐	Massage therapy ☐	
	Changing positions ☐	Physical therapy ☐	
	Other:	Chiropractic ☐	
		Pain management injections ☐	Acupuncture ☐
		OTC NSAID's (Advil, Aleve) ☐	Aquatic Therapy ☐
		Acetaminophen ☐	Other:
		Prescription NSAIDs ☐	
		Narcotic pain medication ☐	
		Rest ☐	
		Other:	

Piedmont
PHYSICIANS

Pain Questionnaire

Please put a X beside **worst** area of pain.
Please also indicate what level your pain is at its best; on average most of the time and at its worst using 0-10. **0** is no pain and **10** is the worst pain you can imagine

	X	Best	Average	Worst	Any other Comments?
Neck	☐				
Left Arm	☐				
Right Arm	☐				
Both Arms	☐				
Upper Back	☐				
Lower Back:	☐				
Left Leg	☐				
Right Leg	☐				
Both Legs	☐				

Piedmont HEALTHCARE

Medical History

Full name:_____ Date of birth:_____ Date:_____

Primary doctor:_____

Doctor who requested today's visit: _____

List current/previous doctors and their specialty:_____

_____

ALLERGIES AND REACTIONS

_____

_____

_____

_____

MEDICATIONS (list dosage and how you take them, including non-prescription, herbs, birth control)

_____

_____

_____

PAST MEDICAL ILLNESSES (please check if you have had the following):

- ❑ Alcohol/Drug addiction
- ❑ Anemia
- ❑ Aneurysm
- ❑ Anxiety disorder
- ❑ Arthritis
- ❑ Asthma
- ❑ Blood disorder
- ❑ Blood clot
- ❑ Blood transfusion
- ❑ Cancer (type):
  - ❑ Breast ❑ Ovarian
  - ❑ Colon ❑ Uterine
  - ❑ _____
- ❑ Crohn's disease
- ❑ COPD/Emphysema
- ❑ Depression
- ❑ Diabetes
- ❑ Glaucoma
- ❑ Gout
- ❑ Hay fever
- ❑ Heart disease
- ❑ Heart murmur
- ❑ Hepatitis B or C
- ❑ High cholesterol
- ❑ HIV
- ❑ Hypertension
- ❑ Kidney disease
- ❑ Kidney stones
- ❑ Liver disease
- ❑ Seizure
- ❑ Sexually transmitted disease (type):
  _____
- ❑ Sickle cell disease
- ❑ Sleep apnea
- ❑ Stomach ulcer
- ❑ Stroke
- ❑ Thyroid disease
- ❑ Tuberculosis
- ❑ (Positive) TB skin test
- ❑ Ulcerative colitis
- ❑ Other:_____

OPERATIONS	DATES	HOSPITALIZATIONS	DATES

FAMILY HEALTH HISTORY ❑ Adopted

Family Members	Major Medical Problems	If Deceased, Causes	Age at Death
Maternal Grandmother			
Paternal Grandmother			
Maternal Grandfather			
Paternal Grandfather			
Mother			
Father			
Brothers and Sisters 1) ❑ M ❑ F			
2) ❑ M ❑ F			
3) ❑ M ❑ F			
Sons and Daughters 1) ❑ M ❑ F			
2) ❑ M ❑ F			
3) ❑ M ❑ F			

SOCIAL HISTORY

Occupation: Marital Status: Children: ❑ Yes ❑ No

Do you drink alcohol? ❑ Yes ❑ No How often? How many drinks?

Do you smoke? ❑ Yes ❑ No Packs per day: ❑ ¼ pack ❑ 1½ packs How many years?_____

Are you a former smoke? ❑ Yes ❑ No ❑ ½ pack ❑ 2 packs Year quit?_____

Do you chew tobacco? ❑ Yes ❑ No ❑ 1 pack ❑ Other:_____

Do you use recreational/illegal drugs? ❑ Yes ❑ No

Have you worked with asbestos or other hazardous materials? ❑ Yes ❑ No

Do you have a living will? ❑ Yes ❑ No Healthcare proxy? ❑ Yes ❑ No If so, who?

Advanced Directive for Healthcare

HEALTH MAINTENANCE

Last menstrual period:_____ Last pap smear:_____ Last mammogram:_____

Last colonoscopy:_____ Last prostate cancer screening:_____ Last bone density scan:_____

Immunizations: ❑ Pneumovax:_____ ❑ Flu:_____ ❑ Tetanus:_____ ❑ Hep A:_____ ❑ Hep B:_____

REVIEW OF YOUR SYMPTOMS (please check if you have recently had the following symptoms):

❑ Weight gain	❑ Persistent cough	❑ Blood in stool	❑ Headaches
❑ Weight loss	❑ Chest discomfort	❑ Difficulty urinating	❑ Memory loss
❑ Night sweats	❑ Palpitations	❑ Trouble holding urine	❑ Numbness/Tingling
❑ Weakness	❑ Fainting	❑ Frequency of urination	❑ Tremor
❑ Fatigue	❑ Change in exercise tolerance	❑ Penis discharge	❑ Uncontrollable mood swings
❑ Insomnia	❑ Difficulty swallowing	❑ Vaginal discharge/bleeding	❑ Anxiety
❑ Change in hearing	❑ Indigestion or heartburn	❑ Nipple discharge	❑ Depression
❑ Change in vision	❑ Nausea	❑ Breast pain	❑ Skin Rash
❑ Runny nose	❑ Vomiting	❑ Breast lump	❑ Back pain
❑ Nose bleed	❑ Constipation	❑ Pain with intercourse	❑ Leg pain
❑ Fever	❑ Diarrhea	❑ Feeling too hot	❑ Leg swelling
❑ Blood in sputum	❑ Change in bowel habit	❑ Feeling too cold	❑ Other:_____
❑ Shortness of breath	❑ Blood in vomit	❑ Dizziness	

Please list all your reason(s) for visiting today in order of priority:

1. _____

2. _____

3. _____

_____ _____ _____ _____

Patient/Designee signature Patient name (**PRINT**) Date Time

_____ _____

Relationship to patient Reason patient is unable to sign