Piedmont ONCOLOGY

Date: _____

## PATIENT

_____ _____ _____
Patient's Last Name First Name Middle Initial

_____ _____
Mailing Address City/State/Zip

_____ _____ _____
Home Phone Cell Phone Email

Is it okay to leave messages at this phone number? ☐ yes ☐ no

Do you have a Medical Advance Directive? ☐ yes ☐ no If yes, please provide a copy

Sex ☐ Male ☐ Female Birthplace: _____

_____ _____ _____ _____
Date of Birth Social Security # Marital Status Race

Employment Status: ☐ Full Time ☐ Part Time ☐ Self Employed ☐ Not Employed ☐ Retired
**If retired, date of retirement: _____

## SPOUSE/EMERGENCY CONTACT

_____ _____
Name Relationship to Patient

_____ _____ _____
Date of Birth Social Security # Phone #

## **MEDICAL INFORMATION**

_____ _____
Diagnosis Date or Onset of Illness

_____ _____
Referring Physician Primary Care Physician

Revised 02/2021

At **Peachtree Radiation Oncology**, we'll take great care of you.

Our dedicated staff delivers compassionate and comprehensive care. We collaborate with your team of healthcare professionals and together provide a multidisciplinary approach responsive to the needs of you and your family. Our physicians and staff are always available to answer questions from you and your family on your journey back to health. We are very pleased you have chosen us for your care.

**Locations**
Piedmont Atlanta Hospital – 1968 Peachtree RD NW, Atlanta, GA 30309
Piedmont West - 1800 Howell Mill RD NW, Suite LL10, Atlanta GA 30318

**Phone Number** – 404.425.7900

**Patient Financial Responsibilities**
Peachtree Radiation Oncology is a private practice affiliated with Piedmont Healthcare. Our fees are billed separately from hospital charges. Overdue balances may be turned over to collections and reported to the credit bureaus.

**Self-Pay Patients**
We welcome patients without insurance. Financial arrangements must be made prior to your scheduled appointment by calling our Accounts Specialist at 404.669.6227 or email Billing@PeachtreeRadOnc.com

**Insurance\Referrals**
We accept most major insurance plans and will file insurance claims on your behalf. If co-payments, coinsurances and/or deductibles are required by your insurance plan, you will be billed for them after your insurance claim has been processed.

If your plan requires a referral, please be sure it is completed **prior to your visit** to avoid being charged the full visit amount.

Are you currently receiving **Hospice** benefits? Yes_____No _____
If yes, please provide the Hospice name and contact information so we may authorize services before they are rendered:

Hospice Name : _____
Hospice Contact : _____
Hospice Phone Number : _____

**Primary Insurance**
Insurance Company: _____
Insured's Name: _____ Date of Birth: _____
ID Number: _____ Group Number: _____

**Secondary Insurance**
Insurance Company: _____
Insured's Name: _____ Date of Birth: _____
ID Number: _____ Group Number: _____

**Payment of Insurance Benefits**
I authorize payment to Peachtree Radiation Oncology for provided medical services. I understand that I am responsible for the amount not covered by insurance.

X
_____

Patient Signature Date Time

**Release of Medical Information**
I authorize the release of information necessary for Peachtree Radiation Oncology to process insurance claims and for the coordination of care with other medical providers. This information will be treated with strict confidence and reasonable efforts used to maintain confidentiality and prevent disclosure as permitted or required by law.

X
_____

Patient Signature Date Time

**RECEIPT OF NOTICE OF PRIVACY PRACTICES**

I, _____ have received and reviewed a copy of the Notice of Privacy Practices. Our goal is to assure your privacy and follow all HIPAA guidelines. Please provide any special requests or restrictions:

I authorize my Protected Health Information (PHI) may be released, if necessary, to the following person(s) including:

_____
Name Relationship Phone Number

X
_____
Signature of Patient or Legal Guardian Date Time

**Peachtree Radiation Oncology Services**

I_____The undersigned (the "Patient"), having healthcare benefit coverage through a group (including a self-funded and employer/employee benefit plan), Medicare, Medicaid and/or individual healthcare plan (collectively, the "Plan"), hereby appoint and assign as my authorized representative, **Peachtree Radiation Oncology Services** (the "Provider"), to include assigning the right to pursue payment for benefits, and take any and all necessary steps, including pursing administrative appeals and remedies, filing suit and all causes of action wholly in my stand for benefit payment of all medical benefits otherwise payable to the Patient for medical services, treatments, therapies, and/or medications rendered or provided by the Provider under the Plan, regardless of the Provider's managed care network participation status. The Patient hereby appoints the Provider, MedRevenue Solutions, LLC and/or the Provider's appointed business associates, the Patient's rights, title, and interests in and to, and related to the recovery of, any and all benefits which the Patient is entitled to receive under the Plan or insurance policy, and authorizes the Provider to release all medical information necessary to pursue and process the Patient's benefits and claims thereunder. I certify that the health insurance information that I provided is accurate. I hereby authorize provider. to submit claims, on my and/or my dependent's behalf, to the benefit plan (or its administrator). I also hereby instruct my benefit plan (or its administrator) to pay the Provider directly for all services rendered to me or my dependents. To the extent that my current policy prohibits direct payment to provider, I hereby instruct and direct my benefit plan (or its plan administrator) to provide governing plan documentation stating such non-assignment to myself and the provider upon request and its standing to governing laws. Upon proof of such non-assignment, I instruct my benefit plan (or its administrator) to make the check payable to me and mail it directly to the provider. I understand that I am responsible for all amounts not covered by my health insurance, including co-payments, co-insurance, and deductibles. I understand, agree and hereby certify that I am obligated to pay, as charged and billed for global service charges, regardless if the above services are covered under my health insurance or plan. I understand that "Deductible" is defined, under the Uniform Glossary from ERISA & the Patient Protection & Affordable Care Act (ACA) as: "*The amount you owe for healthcare services your health insurance or plan covers before your health insurance or plan begins to pay,*" and that I have no knowledge of any plan exclusion or limitation for the charges for healthcare services rendered by the above listed provider, in case that I can't afford to pay for 100% deductible. I understand the payments are due at the time of the services unless otherwise applicable to any PPO or ACA discount once my claim for benefits is processed in full compliance with plan terms and governing laws. I understand I am fully protected against any unexpected medical bills or charges by my provider's applicable ACA or indigency discount policy; including any non-compliant or arbitrary and capricious PPO Discounts or Re-pricing Discounts received from my health insurance plan. My satisfaction is guaranteed in connection with my provider's proactive reasonable efforts to collect or make a good faith determination for ACA Discount qualifications solely based on my unique ability to pay and individual health need. I hereby assign billed charges for healthcare services rendered as my legal claims to the above listed provider as full payment, as my authorized representative, and an ERISA or ACA claimant, to claim or legally pursue proper payment of benefits from my health insurance or plan.

I hereby irrevocably designate, authorize and appoint the Provider, MedRevenue Solutions, LLC, its attorneys or other designated business associate as my true and lawful attorney-in-fact to: (1) release any information necessary to my health benefit plan (or its administrator) regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; to make any request; to present or to produce evidence; to file and obtain any claim, appeal or external review information; to receive any notice in connection with my claim, appeal or external review; wholly in my stead. (3) To file and participate in any administrative or judicial review process; obtain information or submit evidence regarding the claim to the same extent as me; and make statements about facts or law. (4) to act as my authorized representative in connection with my request for an external review by the HHS Federal External Review Process. I authorize this individual to make any request; to present or to produce evidence; to obtain external review information; and to receive any notice in connection with my external review, wholly in my place. I understand that personal medical information related to my appeal may be disclosed to the representative indicated below; (5) to give the provider and its attorneys standing to pursue payment and file suit for benefits and any fiduciary breach and all causes of action available under ERISA and Section 502, 27 § U.S.C. 1132(a); (6) to pursue all necessary benefit payments, appeal rights, remedies and all causes of action, wholly in my stead; (7) to pursue a claim for benefits and to recover all applicable penalties for any fiduciary breach or failure by my plan, its fiduciary and/or its claims administrator to comply with 29 USC § 1132 and (8) allow a photocopy of my signature to be used to process insurance claims. This power of attorney is hereby provided for the limited purpose of receiving all payments, rights and remedies due under my governing Health and Welfare Plan or policy to include all benefits entitled for all services rendered and/or ordered by my treating physician. This power of attorney will remain in effect until all benefits are paid in full compliance of applicable federal and state laws. I hereby confirm and ratify all actions taken by my attorney-in-fact pursuant to the authority granted herein. This order will remain in effect until revoked by me in writing. I authorize Provider or MedRevenue Solutions, LLC, its attorneys, or designated business associate to make any request, file and obtain appeals information, receive any notice in connection with my healthcare services, benefits, appeal, take legal action or other rights, wholly in my stead. Further, I hereby authorize my plan administrator, fiduciary, insurer, and/or attorney to release to the above-named health care provider or its designated business associated any and all relevant Plan and claim documents, requested disclosures, complete insurance policy, and/or settlement information upon written request from the provider, its attorneys or designated business associates in order to secure and claim such medical benefits. I authorize the release or disclosure of my protected health information to my authorized representative in order to secure and claim medical benefits due. I understand that I will be held financially responsible for all fees accumulated for collection agency fees. Administrative fees, attorney fees and court costs incurred by the provider listed above for any delinquent account requiring outside collection assistance, to the fullest extent of the law. I understand revocation of this appointment will not affect any action taken in reliance on this appointment before my written notice of revocation is received. Unless revoked in writing, this assignment is valid for any and all requested administrative and judicial reviews rightfully due me under my governing plan or policy and to the fullest extent permitted by law. A photocopy of this assignment is to be considered valid, the same as if it was the original. I understand that, by signing this form, I am confirming my appointment of my authorized representative, the scope of my authorized representative's authority, and the option of revoking of this appointment. I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT

| _____ | _____ | _____ |
|---|---|---|
| Patient/Guardian/Insured Signature | Employer Group Name Covering Benefits | 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 use and release information contained in the patient record as described in the PHC Notice of Privacy Practices and as otherwise permitted or required by law. The information authorized to be used or released will 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 and hereby releases PHC, its agents and employees from any and all liabilities, responsibilities, damages, claims and expenses arising from the use and release of information as authorized above. Permissible uses and disclosures include, but are not limited to, disclosures to insurance companies, their agents or other third party payors and/or government or social service agencies that may or will pay for any part of the medical/hospital expenses incurred or authorized by representatives of PHC; alternate care providers, including community agencies and services, for post-hospital care, as ordered by Patient's physician or as requested by Patient or Patient's family or as otherwise permitted by law; or PHC affiliates and contractors for PHC operations purposes, such as quality improvement, compliance and risk assessment activities. **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**. By consenting to treatment and accepting financial responsibility for any such treatment, Patient also understands and acknowledges that (a) PHC, from time-to-time, may call and/or text the cell number Patient has provided or email treatment-related information to Patient, such as appointment and exam confirmations and reminders, wellness checkups, hospital pre-registration instructions, pre-operative instructions, post-discharge follow-up, prescription notifications, Medicare-required surveys, and home healthcare instructions and (b) Patient's preferences to receive, change or stop these and other types of communications from Piedmont may be done by logging into the Piedmont MyChart Patient Portal at any time.

**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.

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**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 |

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 use and release information contained in the patient record as described in the PHC Notice of Privacy Practices and as otherwise permitted or required by law. The information authorized to be used or released will 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 and hereby releases PHC, its agents and employees from any and all liabilities, responsibilities, damages, claims and expenses arising from the use and release of information as authorized above. Permissible uses and disclosures include, but are not limited to, disclosures to insurance companies, their agents or other third party payors and/or government or social service agencies that may or will pay for any part of the medical/hospital expenses incurred or authorized by representatives of PHC; alternate care providers, including community agencies and services, for post-hospital care, as ordered by Patient's physician or as requested by Patient or Patient's family or as otherwise permitted by law; or PHC affiliates and contractors for PHC operations purposes, such as quality improvement, compliance and risk assessment activities. **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.** By consenting to treatment and accepting financial responsibility for any such treatment, Patient also understands and acknowledges that (a) PHC, from time-to-time, may call and/or text the cell number Patient has provided or email treatment-related information to Patient, such as appointment and exam confirmations and reminders, wellness checkups, hospital pre-registration instructions, pre-operative instructions, post-discharge follow-up, prescription notifications, Medicare-required surveys, and home healthcare instructions and (b) Patient's preferences to receive, change or stop these and other types of communications from Piedmont may be done by logging into the Piedmont MyChart Patient Portal at any time.

**8. 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.

**9. 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

# 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:

# NOTICE OF PRIVACY PRACTICES

*THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.*

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

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

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

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

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

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

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

**For Public Health Activity:** Piedmont Providers may disclose PHI to government officials in charge of collecting information about births and deaths, preventing and controlling disease, reports of child abuse or neglect and of other victims of abuse, neglect or domestic violence, reactions to medications or product defects or problems, or to notify a person who may have been exposed to a communicable disease or may be at risk of contracting or spreading a disease or condition.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**If you have any questions about this notice:** Please contact the Piedmont Healthcare Privacy Officer at (404) 425-7350; e-mail: privacy.officer@piedmont.org. address: 1800 Howell Mill Road, Suite 350, Atlanta, GA 30318

EFFECTIVE: March 1, 2003 REVISED: February 11, 2013 [34747P Rev. 08/13]

Piedmont HEALTHCARE

# Authorization For Use/ Disclosure of Protected Health Information

| **PATIENT INFORMATION**: The following information is needed to assist the provider in locating the patient's medical record | | |
|---|---|---|
| Patient Name: | Patient Date of Birth: | |
| Patient Street Address: | | Phone: |
| City/State/Zip: | Email Address: | Cell/Alternate #: |

**REQUEST AUTHORIZATION**: I hereby authorize Piedmont Healthcare to disclose records from facility checked below

| Piedmont Provider | Phone | Fax | Piedmont Provider | Phone | Fax |
|---|---|---|---|---|---|
| ❑ Piedmont Athens Regional Medical Center | 706-475-3361 | 706-475-6961 | ❑ Piedmont Newton Hospital | 770-385-4235 | 678-625-2068 |
| ❑ Piedmont Atlanta Hospital | 404-605-3280 | 404-605-5551 | ❑ Piedmont Rockdale Hospital | 770-918-3372 | 770-918-3389 |
| ❑ Piedmont Fayette Hospital | 770-719-6825 | 770-719-6821 | ❑ Piedmont Walton Hospital | 770-267-1880 | 404-367-7248 |
| ❑ Piedmont Heart Institute | 404-605-5570 | 404-355-4739 | ❑ Other: | | |
| ❑ Piedmont Henry Hospital | 678-604-5844 | 678-604-5076 | ❑ Other: | | |
| ❑ Piedmont Medical Care Corporation | 678-423-6633 | 404-609-7543 | ❑ Other: | | |
| ❑ Piedmont Mountainside Hospital | 706-301-5455 | 706-301-5353 | ❑ Other: | | |
| ❑ Piedmont Newnan Hospital | 770-400-4181 | 770-304-4218 | ❑ Other: | | |

**DISCLOSURE**: Records to be disclosed to the person or entity listed below by: ❑ Mail ❑ Secure E-mail Portal ❑ Pick up at location checked above

| | | |
|---|---|---|
| Name: | | |
| Street Address: | | |
| City/State/Zip: | | |
| Phone: | | Fax: |
| Purpose: | ❑ Patient/Representative request | ❑ Other: |

**DESCRIPTION OF INFORMATION FOR RELEASE**: **The applicable dates of service →**:

| | | | |
|---|---|---|---|
| ❑ Entire Medical Record | ❑ Emergency Room Record | ❑ Pathology Slides/Blocks | ❑ Financial Record |
| ❑ Abstract of Record* | ❑ Cardiac Cath Report/CD | ❑ Radiology Film/CD | ❑ Other: |

*An abstract of the record includes the History/Physical Report, Operative, Consultation and Discharge Summary Reports and diagnostic test results.

## Authorization For Use/Disclosure of Protected Health Information

I understand that the information that I am authorizing the above Piedmont Provider(s) to use/disclose may include information related to the diagnosis or treatment of mental illness, substance abuse, chemical dependency, and alcohol abuse, including privileged psychiatric or psychological communications and other detailed mental health information; infectious diseases, such as HIV/AIDS, venereal disease, tuberculosis or hepatitis; and genetic testing or information derived from genetic testing. I hereby waive any privilege concerning such information for the disclosure to the person or entity I have authorized above. I understand that the information used/disclosed pursuant to this authorization will not include psychotherapy notes, which are notes recorded by a mental health professional documenting or analyzing contents of conversation during a counseling session that are kept separate from the rest of the medical record.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of the information and may then no longer be protected by the federal privacy regulations.

I understand that unless otherwise limited by state or federal regulations, I may revoke this authorization at any time by presenting my revocation in writing to the Piedmont Healthcare entity checked above, except to the extent that such entity has taken action in reliance on this authorization. I understand that a revocation form may be obtained from the Piedmont Healthcare entity checked above.

I understand that this authorization is specific to the information, purpose and date(s) of services indicated above. I further understand that this authorization is valid for 90 days from today's date and will expire at that time unless another date is written here →:

Lastly, I understand that Piedmont Providers shall not condition treatment on the receipt of this authorization, except when such conditioning is permitted for research-related treatment or in instances where the sole purpose of creating the health information is for disclosure to a third party, for example a fitness-for-duty exam.

**Note: There may be fees for provision of the information requested; however, records for treatment purposes may be faxed to the patient's healthcare provider when requested at no charge. Under most circumstances, applicable law permits up to thirty (30) days for record requests to be processed.**

| **Patient or Legal Representative signature** | **Please PRINT name** | **Today's date** | **Time** |
|---|---|---|---|

As Legal Representative, my relationship to the patient is:_____. Any document proving such authority must be attached.

The patient is unable to sign because:_____

Piedmont ATLANTA

*Record Label*

## Medicare Off-Campus Co-insurance Notice

This facility is operated as an outpatient department affiliated with Piedmont Atlanta Hospital. As an outpatient department of the hospital, it is considered to be a provider-based department. As a receiver of services at this facility, you are a patient of a Piedmont Atlanta Hospital. Medicare regulation requires the hospital to provide you with a notice of your potential financial liability for the hospital service(s) you will receive. Your coinsurance liability for hospital services is separate from the Medicare coinsurance liability you may owe for any physician or professional services provided to you in conjunction with these hospital services.

We are required to advise you that because a department of the hospital furnishes the services, you will incur a coinsurance liability to the hospital that you would otherwise not incur if the services were furnished in an entity that is not hospital-based. Since this hospital does not know the exact type and extent of services that you may need it is unable to provide you with an estimate of your liability. However, the typical co-insurance incurred by a beneficiary per procedure to this department normally ranges between **$0 and $ 1,216.00**

The actual amount of your coinsurance liability to the hospital may be different from any estimate that is provided above. Actual coinsurance liability will be based on the services that you receive and also subject to final determination by the Medicare Program.

If you are enrolled in the state medical assistance program, Georgia Medicaid, your coinsurance liability may be reduced or eliminated by law. Please make sure you have provided us a copy of your Medicaid card.

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**I have read the foregoing and understand that I may incur a liability to the hospital for Medicare coinsurance as permitted by Law.**

| 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 ONCOLOGY

Name: _____
DOB: _____
MR#: _____

# AUA *American Urologic Association Symptom Score*

| **Over the Past Month** *(Circle One Number for each Line)* | Not At All | Less than 1 in 5 times | Less than half the time | About half the time | More than half the time | Almost always |
|---|---|---|---|---|---|---|
| How often have you had the sensation of not emptying your bladder completely after you finished urinating? | 0 | 1 | 2 | 3 | 4 | 5 |
| How often have you had to urinate again less than 2 hours after you finished urinating? | 0 | 1 | 2 | 3 | 4 | 5 |
| How often have you found you stopped and started several times while urinating? | 0 | 1 | 2 | 3 | 4 | 5 |
| How often have you found it difficult to postpone urination? | 0 | 1 | 2 | 3 | 4 | 5 |
| How often have you had a weak urinary stream? | 0 | 1 | 2 | 3 | 4 | 5 |
| How often have you had to strain to begin urination? | 0 | 1 | 2 | 3 | 4 | 5 |
| How many times a night do you most typically get up to urinate? | 0-None | 1 time | 2 times | 3 times | 4 times | 5 or more times |

**Total:** _____

# SHIM *Sexual Health Inventory for Men*

| **Over the Past 6 Months** *(Circle Once Number for each Line)* | Did not attempt/ No sexual activity | Never/ Almost never/ Extremely difficult | A few times/ Less than half/ Very difficult | Sometimes/ About half the time/ Difficult | Most times/ More than half/ Slightly difficult | Always/ Almost always/ Not difficult |
|---|---|---|---|---|---|---|
| How do you rate your confidence that you could get and keep an erection? | 0 | 1 | 2 | 3 | 4 | 5 |
| With sexual stimulation, how often were your erections hard enough for penetration (entering your partner)? | 0 | 1 | 2 | 3 | 4 | 5 |
| During sexual intercourse, how often were you able to maintain your erection after penetration (entering your partner)? | 0 | 1 | 2 | 3 | 4 | 5 |
| During sexual intercourse, how difficult was it to maintain your erection to completion of intercourse? | 0 | 1 | 2 | 3 | 4 | 5 |
| When you attempted sexual intercourse, how often was it satisfactory for you? | 0 | 1 | 2 | 3 | 4 | 5 |

**Total:** _____