AUTHORIZED PATIENT NOTIFICATION LIST

(Required of HIPAA) Health Insurance Portability and Accountability Act

I authorize all Hughston Physicians and/or whomsoever he/she may designate as his/her professional representative/assistant to discuss any aspect of my medical care, to include: appointments, tests, test results, surgical procedures, prescriptions and any other pertinent information with the following persons in order to facilitate and coordinate my care, treatment and payment:

NAME	Relationship	Phone Number(s)

☐ I do not want to designate anyone to have authorization at this time.

This document will be a part of your permanent record. In the event any of the selected representatives that you have designated change, it will be necessary to update our records with a written notification. You will need to state who you would like to have removed from or added to the Authorized Notification List.

______________________ PATIENT'S NAME PRINT ______________________ SIGNATURE ____________ DATE

______________________ LEGAL GUARDIAN/OTHER AUTHORIZED PERSON PRINT ______________________ SIGNATURE ____________ DATE

HIPAA NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you may get access to this information. Please review it carefully and sign where indicated to acknowledge your understanding of the information.

Hughston is dedicated to protecting your medical information. We are required by law to maintain the privacy of protected information and to provide you with this Notice of our legal duties and privacy practices with respect to protected health information. Hughston is required by law to abide by the terms of this Notice.

How your medical information will be used and disclosed:
We will use your medical information as part of rendering patient care. For example, the business office may use your medical information to process your payment for services rendered or administrative personnel may use your medical information to review the quality of the care provided.

We may also use and/or disclose your information in accordance with Federal and State law without your consent for the following purposes:

- **Appointment Reminders** – to provide appointment reminders
- **Treatment Information** – other alternative treatments or health-related services that may be of interest to you
- **Law Enforcement** – as required during an investigation
- **Legal Proceeding** – in the course of certain judicial or administrative proceeding.
- **Public Safety** – to prevent or lessen serious threat to the health or safety of the public
- **Military Activity and National Security** – to military command for their military records or other federal officials conducting national security and intelligence activities for protective services for the President
- **Workers' Compensation** – as authorized to workers' compensation or similar programs
- **Inmates** – to the correctional facility or law enforcement official for your proper care
- **Abuse or Neglect** – when it concerns abuse, neglect or violence in accordance to Federal or State law
- **Coroner, Medical Examiner or Funeral Director** – for identification of a body or to determine cause of death
- **Food and Drug Administration** – to report adverse events, product recalls or to make repairs or replacements
- **Research** – for certain research purposes if an Institutional Review Board that has reviewed the research proposal and established protocols to ensure the privacy of your information
- **Department of Health and Human Services** – for public health purposes to help control disease, injury or disability, as well as to a person who may have been exposed to a communicable disease or at risk of contacting or spreading a disease or condition
- **Health Oversight Activities** – for activities authorized by law, such as audits, investigations or inspections. Oversight agencies seeking this information include government agencies that oversee healthcare systems, government benefit programs and other government regulatory programs and civil rights law
- **Disaster Relief** – to a public entity, such as the American Red Cross, for the purpose of coordinating with that entity to assist in disaster relief efforts
- **Facility Directory** – your name and the location at which you are receiving care in our facility directory to be used only when someone calls and asks for you by name, unless you object
- **Business Associates** – to provide services on our behalf. We require our business associates to appropriately safeguard the health information of our patients and we require that they sign a contract as our Business Associate.

We will not use or disclose your medical information for any other purpose than those stated above without your written authorization.

AUTHORIZATIONS

Authorizations are required for:

- Most uses and disclosures of psychotherapy notes, where appropriate
- For marketing purposes
- Disclosures that constitute sale of protected health information

Once given, you may revoke your authorization in writing at any time. To request a Revocation of Authorization form, you may contact:

Hughston -Medical Records
1-800-331-2910

SUMMARY

By law, we are required to provide you with our Notice of Privacy Practices (NOPP). This notice describes how your medical information may be used and disclosed by us. It also tells you how you can obtain access to this information.

As a patient, you have the following rights:

- The right to inspect and copy your information.
- The right to request corrections to your information.
- The right to request that your information be restricted.
- The right to request confidential communications.
- The right to a report of disclosures of your information.
- The right to a paper copy of this Notice.
- The right to file a complaint if you feel your privacy has been violated.
- The right to opt-out of fundraising communications. (The Hughston does not contact patients for fundraising.)
- The right to restrict certain disclosures of your protected health information to a health plan when you have paid out of pocket in full for the healthcare item or service.
- The right to be notified following a breach of unsecured protected health information.

We want to assure you that your medical/protected health information is secure with us.

Acknowledgement of Notice of Privacy Practices

I hereby acknowledge that I have read Hughston's NOTICE OF PRIVACY PRACTICES. **I understand that I may request a copy of this Notice. I further understand that if I have questions or complaints regarding my privacy rights, I may contact the Privacy Officer at 706-494-3400 or 800-331-2910.**

____
Patient or Representative Name (Please print)

____ _________________________________
Patient or Representative Signature **Date**

☐ **Patient refused to sign**

☐ **Patient was unable to sign because** ____

Documented by: ____

FINANCIAL POLICY

Thank you for choosing Hughston as your specialty healthcare provider. We are committed to providing you with the best available medical care, our staff will be available to discuss our fees and this policy with you. The services you have elected to participate in will result in a financial responsibility on your part. Payments for all services will be due at the time services are rendered. For your convenience, we accept cash, check, Visa, MasterCard, Discover and American Express. As a courtesy to you, we will verify your coverage and bill your insurance carrier on your behalf; however, you are ultimately responsible for payment in full. As the responsible party, please understand:

(PLEASE INITIAL THE FOLLOWING)
_____Your insurance policy is a contract between you, your employer (if applicable) and your insurance provider. Our relationship is with you, not your insurance provider. We will not become involved in disputes between you and your insurer regarding deductibles, co-payments, covered charges, secondary insurance or "usual and customary" charges. As your medical provider, we will only communicate factual information to facilitate claims processing.
_____I understand that I may have an insurance plan with limitations or restrictions on physical/occupational therapy services and it is my financial responsibility for the difference between services covered by my policy and the actual services provided.
_____I understand that I will be charged a $25.00 No Show fee if I fail to cancel my provider appointment within 24 hours of my appointment time. Procedure/Test No Show fees may vary depending on the type of service scheduled. This fee is due before an appointment can be rescheduled.
_____Fees for services, which include unpaid balances, deductibles, co-payments and coinsurance, are due at the time of service. I understand should I receive therapy; co-pay will be due at the time of service for each visit. I understand and agree if I fail to make payments for which I am responsible within three statement billing cycles, after such default and upon referral to a collection agency or attorney by Hughston, I will be responsible for all costs of collecting monies owed including collection agency fees.
_____All charges are my responsibility. If my insurance carrier does not remit payment within sixty days, the balance may be due in full from me. If any payment is made directly to me for services billed by Hughston Facility, I recognize my obligation to promptly remit payment to Hughston.
_____I understand should I incur a balance that I am unable to pay within three billing cycles, I am required to contact Hughston to set up a formal payment plan.
_____ I understand that should my balance be deferred to a collections agency; payment of delinquent balance is due in full prior to new services being scheduled/rendered.
_____Completion of disability and/or FMLA forms are not billable/reimbursable by insurance carriers, therefore, fees are my responsibility for payment. Hughston fees related to completion of these documents are expected to be paid upon presentation of forms for completion.
_____Returned checks and unpaid balances may be subject to collection placement. If legal action is required, I will be responsible for all costs of collecting monies owed including applicable processing fees and associated legal fees.
_____Hughston utilizes the services of Assistant Surgeons/Physician Assistants/Nurse Practitioners/Fellows/Residents/Audiologists/Therapists/Nurses for medical services including tests, labs and surgical procedures. We will bill your insurance for these services; however, should your insurance deny the charges as non-covered you will be held responsible for any payment(s) due.
_____ I understand credit balances will be allocated to patient responsibility amounts due to other Hughston entities prior to refund submission to responsible party.
_____I give consent to be contacted by my provider and their Designated Business Associates through any communication method, including but not limited to wireless cell phone, text, email and landline telephone. By providing your cellular number you are agreeing to be contacted by the provider and any entity working on the provider's behalf at that cellular number and, if necessary, by an automated dialing or messaging system.

We understand financial problems may affect timely payment, so we encourage you to communicate any such problems, so we may assist you in keeping your account in good standing.

Printed Name of Patient: ____Signature: ____________________________________

Relationship to Patient: ____ Date: ____

Injury/Illness/Accident Information Form:

Chief Complaint/Injury:____

How did you hurt yourself? ____ Date of injury: ________________

Have you been treated by another physician for this problem? Yes No If Yes, who: ________________________________

Did you go to the Emergency Room (ER) for this problem? Yes No If Yes, which ER? ______________________________

Date of ER visit? ____________________ Were x-rays taken? Yes No

☐ My injury/illness is not the result of an accident.

By signing below I, ____, certify that my illness/injury is not the result of an accident.

Patient signature ____

☐ My injury/illness is the result of an accident.

By signing below I, ____, understand that if a "Third Party" is involved and I receive funds from the Third Party, I am responsible for reimbursing my medical insurance company.

Type of injury: Fall Auto Work Sport Other:_______ Date of accident: ___________ Where did the accident occur? _________________

Describe how the accident occurred: ____

If this accident is work related, who is your employer: ____

If this accident is a motor vehicle accident, who is your Auto insurance carrier ________________________ Policy number: ________________

Was this accident the result of a Third Party*? Yes No

(*Third party is someone other than you or your own personal medical insurance that is liable for costs associated with your accident).

Do you have an attorney representing you? Yes No If Yes, attorney's name ________________________________.

ASSIGNMENT OF BENEFITS FOR TREATMENT

I authorize payment and hereby forever assign any and all insurance benefits to which I may be entitled to Hughston (hereinafter sometimes referred to as "Clinic"), including but not limited to, benefits for payment of medical charges under an automobile policy which may provide higher reimbursement rates than a health plan of which I may be a member of for this period of medical, emergency, and/or diagnostic treatments and physician services. I further authorize any such payment to be made directly to Clinic. I expressly authorize Clinic to file any and all claims with any insurance carrier as may be required without any further authorization on my part. I expressly understand, acknowledge, and agree that Clinic coordinates benefits in any situation with multiple potential and/or actual policies which may provide benefits to me and which pay for medical care and treatment. I further authorize, understand, acknowledge, and assign said benefits to be coordinated in any fashion or order Clinic decides or is required to do so under federal regulations, contractually, or otherwise, regardless of whether or not Clinic may be paid at a higher rate for charges by another Payor of benefits. I further acknowledge and authorize Clinic to bill my automobile insurance, including, but not limited to, automobile policy medical payments coverage, uninsured motorist coverage and liability coverage, homeowner's guest medical, accident policy, or any other policy which may provide benefits to me for medical care and treatment prior to billing any applicable health insurance plan which may provide benefit for medical expenses. I further forevermore assign any and all of aforesaid benefits to Clinic. I, the undersigned, authorize Hughston to act on my behalf in pursuing a benefit claim or appeal of an adverse benefit determination. This shall allow Hughston to receive on my behalf all payments otherwise due under any insurance policy or benefit plan for services rendered by Clinic, and to direct any insurance company or benefit plan payment of the same directly to Clinic rather than to me. To the extent that any insurance company or benefit plan does not comply with Clinic's instructions, I agree to hold all payments received from any insurance company of benefit plan on account of services provided by Clinic in trust for the benefit of Clinic, and to remit any such payments directly to Clinic immediately upon my receipt thereof. I further consent, authorize and direct any insurance company or attorney at law retained by me or on my behalf to remit directly to Clinic, for any and all balances owed by me, to Clinic from any and all dates of treatment from any and all benefits I may receive from any insurance policies. I further acknowledge that all sums received by an attorney on my behalf from any and all insurance companies or benefit plan on account of services provided by Clinic are held in trust for the benefit of the Clinic, I consent, authorize, direct and order any attorney retained by me or on my behalf to remit, any and all sums and payments received, to Clinic immediately upon receipt thereof.

I agree that Clinic may provide a copy of this document to any insurance company or benefit plan for all purposes under the insurance company or benefit plan as valid as if I had provided an original signed version thereof. This document authorizes Clinic to accomplish any and all of the foregoing, is coupled with an interest, and is therefore irrevocable. Photocopies of this authorization are as valid as the original.

I understand and acknowledge that this assignment does not relieve me of my financial responsibility to the Clinic, attending physicians, or other treating organizations or health care provider's charges incurred by me or anyone on my behalf, and I hereby accept such responsibility, including but not limited to payment of those fees and charges not directly reimbursed to the Clinic, attending physician, or other organizations by any insurance policy, self-insurance program, or other benefit plan or program. If payment has not been received from the insurance carrier within thirty (30) days from discharge date, the entire balance of this account becomes the responsibility of each of the undersigned. I further acknowledge and agree that any charges not covered under any insurance policy or plan in which Clinic otherwise participates in shall become my full responsibility at full clinic charges, and not at any discounted rates that may have been available under a plan or policy I may have been a beneficiary of, if payment is denied or not covered by any such plan or insurance policy. The undersigned agrees, whether as Agent, Guarantor, or Patient, that in consideration of the services to be rendered to the patient, the undersigned is individually obligated to pay the account in full of the Clinic, and attending physicians, or organizations, or other satisfactory financial arrangements must be made prior to time of patient discharge. Further, should it become necessary to enforce collection of the account, the undersigned singularly and jointly agrees to all such costs of collection and expenses. All delinquent accounts bear interest charges at the legal rate. Further, the undersigned agrees to pay attorney fees if the account is collected by or through an attorney at law.

____ ______________________________

Patient Signature **Signed Date/Time**

Pictures and Audio/Visual Recording Acknowledgement

Thank you for choosing the Hughston ("Clinic") as your healthcare provider. At the Clinic, we believe the physician-patient relationship is very important, which includes protecting all communication between you and your treating Clinic providers. To help in protecting your patient information, the Clinic prohibits the unauthorized taking of pictures and any audio or visual recording while receiving care or guidance from Clinic providers. If there are circumstances in which you feel that you may need to record an encounter with your Clinic provider, this must be approved by the physician in writing prior to your appointment. Please sign below acknowledging that you understand this policy.

Printed Name of Patient: ________________________ Signature: ________________________

Relationship to Patient: ________________________ Date: ________________________

Prescription Medication & Controlled Substances Agreement

Hughston is required to inform you of the risks associated with certain controlled substances. We are committed to the improvement of our patients' functional ability and the use of narcotic pain medications may be suggested at times. Narcotics can be extremely effective. However, incorrect use can lead to abuse and dependency. By initialing below, you acknowledge that you understand and agree to the following terms:

____ I will tell my Hughston physician about all other medication I take and will let my Hughston physician know right away if I have a prescription for any new medication.

____ I will take any medication prescribed to me by my Hughston physician only as instructed and will not change the way I take it without first consulting with my Hughston physician or a member of their team.

____ Prescriptions will only be filled/refilled during scheduled appointments with my Hughston physician. I will request refills during regular office hours only, if unable to make an appointment and in pressing need of a refill, and will not call for refill requests between appointments. I understand that refill requests can take up to 72 hours to fulfill.

____ I understand that my narcotic medications cannot be transmitted electronically to my pharmacy. The signed prescription may only be picked up in person (or by a HIPAA authorized designee) at the office during normal business hours.

____ I will keep my medication safe, secure and out of reach of children. If my prescribed medication is lost or stolen, I understand that it will not be replaced until my next scheduled appointment, if deemed appropriate.

____ I will not sell my prescribed medication or share it with others. If I do, Hughston will stop treatment.

____ I will come in for drug testing and pill counts within 24 hours of being called by my Hughston physician, if requested. I understand that it is my responsibility to ensure that my Hughston physician's office has my current contact information and that any missed tests will be considered positive for drugs.

____ I understand that I may lose my right to treatment by my Hughston physician and their team members if I break any part of this agreement.

Patient Signature: ____ Date: _______________________