GastroenterologyCenter
NavicentHealthPhysicianGroup

Patient intake questionnaire

Name:_______________________________ What would you like to be called by the doctor? _________________

Gender: ☐Male ☐Female **Date of Birth:**_______________
Name of Referring Physician:__________________________________ **Phone:**__________________________

Please list other physicians who you are currently seeing:

Name	Specialty	Problems
1.		
2.		
3.		

Please list the medical problem(s) for which you are here today:

____

Do you currently have the following GI symptoms or problems?

___Heartburn
___Indigestion
___Regurgitation
___Difficulty swallowing
___Painful swallowing
___Hiatal hernia
___Esophageal stricture
___Full after eating a few bites
___Nausea
___Vomiting
___Diarrhea
___Constipation
___Abdominal pain
___Change in bowel habits
___Black, tarry, sticky stools
___Blood in your stool
___Rectal pain
___Stool soilage or leakage
___Coca-cola colored urine
___White chalky stool
___Frequent burping / gas
___Abdominal bloating
___Irritable bowel
___Colitis
___Hemorrhoids
___Jaundice
___Hepatitis
___Cirrhosis
___Liver problems
___Gallstones
___Ulcers
___GERD / acid reflux

Past Medical History

___Heart disease
___Heart attack / MI
___Irregular heartbeat
___Heart failure
___Mitral valve prolapse
___Use of coumadin
___Other blood thinners
___High blood pressure
___Low blood pressure
___High cholesterol
___Seizure / epilepsy
___Stroke / mini-stroke
___Anemia
___Low iron
___Low B12
___Lung disease
___Emphysema
___Bronchitis
___Asthma
___Pneumonia
___Tuberculosis
___Mental illness
___Anxiety
___Depression
___Thyroid disease
___Diabetes
___Type I ___Type 2
___Tingling in feet / hands
_____Year diagnosed
___Adrenal gland disease
___Enlarged prostate
___Endometriosis
___Kidney disease
___Bladder infections
___Kidney stones
___Arthritis
___Psoriasis
___Gout
___Rheumatoid
___Degenerative
___Clotting disorder
___Easy bruising
___Blood clots
___Recurring infections
_____ Date of last antibiotic
___HIV infection
___Cancer
List type and date
____
____
____
____
____
____

Other medical problems: ____

Name of Preferred Pharmacy: ____

Phone Number: __________________________________ **Location:** ________________________

Medications: Please include over the counter meds, laxatives, antacids, birth control and vitamins. Please include strength and how often you take the medication (once a day, twice a day, when needed, etc.) **This is very important!**

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

Do you take aspirin, BC powders, Goody powders, Motrin, Aleve, Advil or other aspirin like products? ____________

Drug Allergies: Are you allergic to any drugs? Please list the name of the drug and the type of reaction the drug caused.

1. ____________________ **4.** ____________________
2. ____________________ **5.** ____________________
3. ____________________ **6.** ____________________

Have you ever had any of the following tests?

___Colonoscopy Date of last exam ____________ Findings ____________________

___Flexible sigmoidoscopy w/ in the last 5 years Findings ____________________

___Upper endoscopy (EGD) Date of last exam ____________ Findings ____________________

___ERCP Date of last exam ____________ Findings ____________________

___Barium enema ___CT Scan of the abdomen ___Upper GI X-ray ___MRI of abdomen

Surgical History: Please list surgeries performed. Please include date, surgeon and location if known

1.______________________________
2.______________________________
3.______________________________
4.______________________________

Family History: Please list any illness, diseases or any other medical history.

Father: ______________________________
Mother: ______________________________
Father's Parents: ______________________________
Mother's Parents: ______________________________
Other: ______________________________

Have any of your immediate family members been diagnosed with cancer? ____ Who? __________ Type? ____

Do you have any family members who have been diagnosed with **colon cancer** or colon polyps? ______________

Social History:

Number of children:____ Marital Status: **M S D W Other:**__________
Occupation (current or previous) ______________ Are you retired? **N** or **Y**
Have you traveled outside the U.S. in the past year? **Y** or **N**
What is your religious preference? ______________ What are your hobbies?______________
What is the highest grade that you completed? __________ and /or degree received? ______________
Do you use tobacco? _____ **Currently** ____ **Previously** Year tobacco started:__________ Year ended:______
What type of tobacco? ___**Cigarettes** ___**Cigar**___ **Smokeless/chewing** How much/many a day:___ or a week ___
Do you use alcohol? **Y** or **N** How many average drinks a day? ______ Type of alcohol? __________

Have you ever –

___ Used illicit drugs? If so, what drugs did you use? ______________________
___ Had a blood transfusion ______ Pierced ears or body piercing(s) ____Tattoo(s)
___ Been diagnosed with a venereal disease?

Do you have or have you had within the past 3 months?
Do not check if symptoms were present more than 3 months ago.

General
- ____ Fevers
- ____ Chills
- ____ Night Sweats
- ____ Anorexia
- ____ Fatigue
- ____ Generalized weakness
- ____ Unexplained weight Loss

Eyes
- ____ Blurring
- ____ Double Vision
- ____ Eye Irritation
- ____ Discharge
- ____ Intermittent vision lose
- ____ Eye pain
- ____ Sensitivity to sunlight

Ears
- ____ Earaches
- ____ Ear discharge
- ____ Tinnitus
- ____ Decreased Hearing
- ____ Nasal congestion
- ____ Nosebleeds
- ____ Sore throats
- ____ Hoarseness
- ____ Difficulty swallowing

Cardiovascular
- ____ Chest pains with exertion
- ____ Heart racing or skipping
- ____ Fainting spells
- ____ Short of breath with exertion
- ____ Short of breath with reclining
- ____ Wake up short of breath
- ____ Swelling of your feet or legs

Females Only
- ____ Vaginal discharge
- ____ Still have menstrual periods
- ____ Excessive bleeding with periods
- ____ Pelvic pains
- ____ Breast lumps
- ____ Breast pain or tenderness
- ____ Discharge from nipples

Date of last menstrual period?____________

Are you pregnant?____

Genitourinary
- ____ Incontinence of urine
- ____ Burning with urination
- ____ Blood in urine
- ____ Frequent urination

Respiratory
- ____ Coughing
- ____ Short of breath
- ____ Excessive sputum
- ____ Cough up blood
- ____ Frequent sneezing
- ____ Wheezing

Male Patients Only
- ____ Testicular pain
- ____ Testicular lumps
- ____ Testicular swelling
- ____ Penile discharge

Musculoskeletal
- ____ Back pain
- ____ Joint pain
- ____ Joint swelling
- ____ Muscle cramps
- ____ Muscle weakness
- ____ Muscle stiffness
- ____ Arthritic pain

Neurologic
- ____ Transient paralysis
- ____ Weakness of the arms or legs
- ____ Numbness in the arms or legs
- ____ Seizures
- ____ Fainting spells
- ____ Tremors
- ____ Headaches
- ____ Vertigo (Illusion of movement, spinning or turning.)

Psychiatric
- ____ Depressed
- ____ Anxious
- ____ Problems with memory
- ____ Suicidal thoughts
- ____ Hallucinations

Skin
- ____ Rashes
- ____ Itching
- ____ Dryness of the skin
- ____ Suspicious moles that are growing or have changed?

Endocrine
- ____ Cold intolerance
- ____ Heat intolerance
- ____ Unusually thirsty
- ____ Constantly urinating
- ____ Recent weight change

Heme/Lymphatic
- ____ Bruise abnormally
- ____ Bleeding easily
- ____ Enlarged Nodes

Allergic/Immunologic
- ____ Breakout in whelps or rash
- ____ Hay fever or allergies
- ____ Persistent infections

Patient Signature____________________________ **Date** ____________________________

PATIENT INFORMATION

Patient Name ______________________
First *Middle* *Last*

Date of Birth ____________ Social Security Number ____________ ☐ Male ☐ Female

Address ______________________

City ____________ State ____________ Zip ____________

Phone Number ______________________
Home ***Cell*** ***Work***

Email Address ______________________

Race (Circle)	Asian, American Indian, African American, White, Hispanic, Other	Primary Language (Circle)	English, Spanish, Indian, Other	Ethnicity (Circle)	Hispanic, Non-Hispanic, Refused to Report

RESPONSIBLE PARTY (If other than patient)

____
First *Middle* *Last*

Date of Birth ____________ Social Security Number ____________ ☐ Male ☐ Female

Employer Name ____________ Employer Number ____________

Employer Address ______________________
City *State* *Zip*

Phone Number ______________________
Home ***Cell*** ***Work***

EMERGENCY CONTACT

1) Name ____________ Ph. Number ____________ Relationship ____________

2) Name ____________ Ph. Number ____________ Relationship ____________

INSURANCE INFORMATION: PLEASE PROVIDE COPIES OF ALL MEDICAL INSURANCE CARDS

PRIMARY INSURANCE

Insurance Company Name ______________________

Policy Number ____________ Group Number ____________

Claims Mailing Address ____________ Phone Number ____________

Cardholders Name ______________________

Cardholders DOB ____________ ☐ Male ☐ Female Cardholders SSN ____________

Cardholders Employer ______________________
Name *Address* *Employer Phone Number*

RELEASE OF PROTECTED HEALTH INFORMATION

Unless you give written permission we will not release you medical information according to the HIPPA guidelines.

Advanced Directive:

☐ I have an Advanced Directive and HAVE NOT provided a copy to my physician

☐ I do not have an Advanced Directive

☐ I have an Advanced Directive and have provided a copy to my physician

If you have someone who you want us to release protected health information to such as a spouse, child, or parent please list:

Name: ____________ Relationship to you: ____________

Name: ____________ Relationship to you: ____________

"I certify the information given above by me is correct. I hereby authorize the release of any medical or other information to any third party payors to be used by them in consideration of payment of any claim results from my treatment. I will not hold this health care entity or its provider responsible for further dissemination of my medical information by the third party. I also authorize release of said information to and from my physicians, state of federal agencies, or other health care providers if needed for continuity of care, quality procedures, to administer treatment, and perform such care as indicated. I consent to the performance of those medical treatments and or procedures in addition to or different from those now contemplated, that may arise from presently unforeseen conditions that may occur during my treatment. I further assign benefits to the physician and understand and agree that I am responsible for any balance due after insurance has been filed. A copy of this authorization may be used in place of the original."

Signature ______________________ Date ____________

Patient's Name Legal Guardian's Name (If Applicable)

Patient's DOB Social Security Number

I, _________________________(patient/guardian) do hereby authorize The Gastroenterology Center to discuss the medical treatment, results of any labs or x-rays or other procedures for _________________________(patient's name) with the following individual(s).

NAME **RELATIONSHIP**

1. ____

2. ____

3. ____

4. ____

Due to my signature below on this authorization The Georgia Gastroenterology center will not be held liable if my medical treatment is discussed and released to the above-referenced persons. This authorization will be in effect until such time as I change the person(s) referenced or withdraw permission.

I specifically do not authorize any medical treatment to be discussed with the following individual(s).

1. ____

2. ____

Date____________ **Signature** ____________________

1014 Forsyth St. Ste. 100 | Macon, GA 31201 | Phone: 478-633-8700| Fax: 478-633-8710 | www.navicenthealth.org/GI

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Please complete the authorization by printing legibly, sign, and date. (DO NOT CHECK ANY OF THE BOXES. WE WILL FILL THAT OUT).

I authorize and request the disclosure of protected information from:

____ (We will fill out this part)

Name of Healthcare Facility to release medical information:

____

Street Address City, State and Zip Code

to release information about the following patient:

Print Patient Name ____________________________ Date of Birth __________________

Street Address City, State, and Zip Code Telephone
Number____

I expressly request that the information in the designated record set be disclosed for date (s) of service:__________________________to include the following:

☐	History & Physical	☐	Lab Reports	☐	Physicians Orders
☐	Discharge Summary	☐	Radiology Reports	☐	Cardiovascular Diag Reports
☐	Consultations	☐	EKG	☐	Urgent Care Records
☐	Operative Reports	☐	Emergency Center	☐	Hospice Records
☐	Pathology Reports	☐	Progress Notes	☐	Other (specify):
☐	Outpatient Rehab Records	☐	Health Center/Clinic	☐	Other (specify):

This protected health information is disclosed for the following purpose (s):

☐	Insurance	☐	Continued Treatment	☐	Legal
☐	Patient's/Representative's			☐	Other, specify

You are authorized to release the above records to the following:

Gastroenterology Center Navicent Healthcare

I understand the following:

a) I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization. I also understand that the written revocation must be signed and dated with a date that is later than the date on this authorization and submitted to The Medical Center of Central Georgia, HIM Department, 777 Hemlock, Hosp. Box 148, Macon, and GA 31201. The revocation will not affect any actions taken before the receipt of the written revocation.

b) My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.

Navicent Healthcare entities and many other organizations and individuals such as physicians, hospitals and health plans are required by law to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.

I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), psychological or psychiatric conditions, and/or alcohol and drug abuse. I authorize the release or disclosure of this type of information.

____

Signature of Patient or Legal Authorized Representative Date

I understand that this authorization will expire in 90 days from the date of execution of this authorization unless I otherwise specify. I desire this authorization to be in effect until

____________________________________.

Expiration date and/or event

____

Signature of Patient or Legal Authorized Representative Date

____

Print Name **Relationship if other than patient**

____

Street Address **City, State, and Zip Code** **Telephone Number**

CONSENT AND TREATMENT AUTHORIZATION
Patient (or the undersigned representative acting on behalf of patient), who is requiring medical care and or treatment, does hereby consent to the rendering of such care and treatment, which may include diagnostic testing procedures and such medical treatment and care as the physician(s) consider to be necessary and appropriate. Patient hereby authorizes NavicentHealth Physician Group affiliates by their physicians, nurses, medical students and other health care professionals to furnish and provide such treatment. I also consent to treatment and care by physicians and healthcare providers who are not employees or agents of NHPG but are authorized by NHPG to provide treatment and care to me as a patients of NHPG affiliate which may be deemed necessary or advisable in the judgment of my physician or other provider. This consent to receive medical treatment includes, but is not limited to, examinations (x-ray or otherwise), laboratory procedures, medications, and medical treatments, and other services which the patient may require.

PATIENT FINANCIAL RESPONSIBILITY FORM
In consideration of services rendered, I hereby transfer and assign to NavicentHealth Physician Group affiliates, including its treating and referring providers and other staff members all rights, title and interest in any payment due to me for services described herein as provided in the above-mentioned policy or policies of insurance. The physician practice/facility may disclose all or any part of the patient's record (including psychiatric, alcohol and drug abuse, family member or employer of the patient for all or part of the clinic's charge, including but not limited to medical service companies, insurance companies, workman's compensation carriers, welfare funds or the patient's employer. The undersigned agrees, whether he/she signs as agent or as patient, that in consideration of the services to be rendered to the patient, he/she obligates himself/herself to pay the account of the physician practice/facility in accordance with the regular rates and terms of the clinic. Should the account be referred to an attorney for collections, the undersigned should pay reasonable attorney's fees and collection expense. The attorney for collections, the undersigned should pay reasonable attorney's fees and collection expense. The authorized by the patient as patient's general agent to execute the above and accepts its terms.

Basic Policy: Services provided by our physician should be paid in full at the time services are rendered.
Non-covered services: A payment for non-covered charges is expected at the time services are rendered.
Elective (Cosmetic) services: Payment in full is required prior to seeing the service provider.
Missed Appointments: If a patient cannot present for an appointment, he/she should cancel the appointment (2) business days prior to the scheduled appointment time. Untimely notification and no-shows may result in charge that is not covered by insurance carriers.
Patients with insurance: In accordance with insurance carrier contracts, patients will be required to pay their ***co-payment.*** NHPG will submit charges for services rendered to the insurance carrier. If the insurance carrier determines there is a patient balance owed a statement will be sent. All balances should be paid upon receipt of statement.
Returned checks: Payments made by check to NHPG that are not honored by the bank will incur a returned check fee of $30.00.

Medicare/Medicaid Patients: I certify that the information given to me in applying for payment under Title XVIII/XIX of the Social Security Act is correct. I authorize that any holder of medical or other information about me to release to Social Security Administration/Division of Family Services or its intermediaries or carries any information needed for this or a related Medicare/Medicaid claim. Patient requests that the payments of authorized benefits be made to NHPG. I hereby certify all insurance pertaining to treatment shall be assigned to the Related Medicare/Medicaid claim. Patient assigns the benefits payable for services rendered by NHPG affiliates and treating physicians and authorizes NHPG affiliates and treating physicians to hereby certify all insurance pertaining to treatment shall be assigned to the physician practice treating me.

I understand that certain insurance claims may be filed as a courtesy. However, if a claim is denied for any reason, I am responsible for payment. Insurance is considered a method of reimbursing the physician for services rendered to the patient. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charges any co-pay, and other pay a percentage of the charges. I understand it is my responsibility to pay deductible, coinsurance, or any other balance not paid for by my insurance or third party payer within a reasonable period of time not to exceed (90) days will be referred to an outside collection agency.

I have read, understand, and agree to the above financial agreement for payment of all fees. The patient/guarantor is ultimately responsible for all fees.

Patient's Signature: ______________________________ **Date:** ________________

GastroenterologyCenter
NavicentHealthPhysicianGroup

NAVICENT HEALTH PHYSICIAN GROUP
NOTICE OF PRIVACY PRACTICES

Notice of Privacy Practices

I have been offered a copy of the Navicent Health Physician Group notice of Privacy Practices.

____

Patient Signature Date

____

Witness Date

Comments:

____

____

____

____

____

____

Central Georgia Health System

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.

As a health care provider, CGHS uses confidential personal health information about patients (also known as "protected health information" or "PHI"). CGHS protects the privacy of this information, and this information is also protected from disclosure by law. In certain specific circumstances, pursuant to this Notice of Privacy Practices, permission from the patient, or applicable laws and regulations, CGHS may use or disclose PHI to other parties. This Notice describes the categories of permitted uses and disclosures.

Uses and Disclosures for Treatment, Payment and Health Care Operations. CGHS may use or disclose PHI about you for purposes of treatment, payment and health care operations without obtaining written authorization from you.

Treatment. CGHS 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. These types of uses and disclosures may occur between physicians, nurses, medical students, and other health care professionals who are involved in your care. For example, if you are being treated by your primary care physician, that physician may need to disclose PHI to a specialist physician with whom he or she consults regarding your condition, or to a nurse who is assisting in your care. Different departments of the hospital also may share medical information about you in order to deliver care to you, such as prescriptions, lab work, and x-rays. CGHS also may disclose medical information about you to people outside CGHS who may provide medical care after you leave the hospital.

Payment. CGHS may use and release PHI in order to bill and collect payment for the health care services provided to you. For example, CGHS may need to give PHI to your insurance company in order to be paid for the services provided to you. CGHS may also disclose PHI to its business associates, such as billing companies, claims processing companies, and others that assist in processing health claims.

Health Care Operations. CGHS may use and disclose PHI as part of its 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; compliance and risk management activities; planning and development; and management and administration. CGHS may disclose PHI to physicians, nurses, technicians, students, attorneys, consultants, accountants and others for review and learning purposes, to help assure that CGHS is complying with all applicable laws, and to help CGHS continue to provide high quality health care to its patients. CGHS also may disclose PHI to other health care providers and health plans for their quality assessment and improvement activities, credentialing and peer review activities, and health care fraud and abuse detection or compliance activities, provided that they have, or have had in the past, a relationship with the patient who is the subject of the information.

Sharing PHI Among CGHS and its Medical Staff. CGHS and the physicians and other health care providers of the CGHS medical staff work together in an Organized Health Care Arrangement to provide medical services to you when you are a patient at CGHS. CGHS and the members of its medical staff will share with each other PHI as necessary to carry out their treatment, payment and health care operations relating to the provision of care to patients at CGHS.

Sharing PHI via a Health Information Exchange. CGHS participates in Georgia Regional Academic Community Health Information Exchange (GRAChIE), a secure network through which your health information is shared with your other healthcare providers as necessary, and as permitted under Federal and State law. You have the right to opt out of GRAChIE. For more info, please call 706-496-4170, or visit www.grachie.org.

Other Uses and Disclosures for Which Authorization is Not Required. In addition to using or disclosing PHI for treatment, payment and health care operations, CGHS may use and disclose

PHI without your written authorization under the following circumstances:

As Required by Law and Law Enforcement. CGHS may use or disclose PHI when required to do so by law. CGHS also may disclose PHI when ordered to do so in a judicial or administrative proceeding: to identify or locate a suspect, fugitive, material witness, or missing person; when dealing with gunshot and other wounds; regarding criminal conduct; to report a crime, the location of the crime or victims, or the identity, description or location of a person who committed a crime; or for other law enforcement purposes.

For Public Health Activities and Public Health Risks. CGHS 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 medicines 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. CGHS may disclose PHI to the government for oversight activities authorized by law, such as: audits, investigations, inspections, licensure or disciplinary actions, and other proceedings, activities necessary for monitoring the health care system, government programs, and compliance with civil rights laws.

Coroners, Medical Examiners, and Funeral Directors. CGHS may disclose PHI to coroners, medical examiners, and funeral directors for the purpose of identifying a decedent, determining a cause of death, or as necessary to enable the parties to carry out their duties according to the law.

Organ, Eye, and Tissue Donation. CGHS may disclose PHI organ procurement organizations to facilitate organ, eye, and tissue donation and transplantation.

Research. Under certain circumstances, CGHS may use and disclose PHI for medical research purposes.

To Avoid a Serious Threat to Health or Safety. CGHS 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.

Specialized government functions. CGHS may use and disclose PHI of military personnel and veterans under certain circumstances. CGHS 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 or to conduct special investigations.

Inmates. Under certain circumstances, CGHS may release to a correctional institution or law enforcement official PHI regarding an inmate of the correctional institution or under the custody of the law enforcement official.

Workers' Compensation. CGHS may disclose PHI to comply with workers' compensation or other similar laws. These programs provide benefits for work-related injuries or illnesses.

Fundraising Activities. CGHS may use certain information (name, address, telephone number or email information, age, date of birth, gender, health insurance status, dates of service, department of service, treating physician, or outcome information) to contact you for the purpose of raising money, and you will have the right to opt out of receiving such communications with each solicitation. For the same purpose, CGHS may provide your name to its institutionally related foundation. The money raised will be used to expand and improve the services and programs CGHS provides to the community. You are free to opt out of fundraising solicitation and your decision will have no impact on your treatment or payment for services. If you do not want CGHS to contact you for fundraising, please contact:

MedCen Community Health Foundation
777 Hemlock Street
Hospital Box 78
Macon, GA 31201

Appointment Reminders; Health-related Benefits and Services. CGHS may use and release your PHI to contact you and remind you of an appointment, or to inform you of treatment alternatives or other health-related benefits and

services that may be of interest to you, such as disease management programs.

Disclosures to You or for HIPAA Compliance Investigations. CGHS may disclose your PHI to you or your personal representative, and it is required to do so in certain circumstances described below in connection with your rights of access to your PHI and to an accounting of certain disclosures of your PHI. CGHS must disclose your PHI to the Secretary of the United States Department of Health and Human Services when requested in order to investigate CGHS's compliance with privacy regulations issued under the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

Uses and Disclosures Subject to State and Other Laws. In addition to the federal privacy regulations that require this notice (called the "HIPAA" regulations), there are Georgia and other federal health information privacy laws. These laws on occasion may require your specific written permission prior to disclosures of certain particularly sensitive information (such as mental health, drug/alcohol abuse, or HIV/AIDS information) in circumstances that the HIPAA regulations would permit disclosure without your permission. CGHS is required to comply not only with the HIPAA regulations but also with any other applicable laws that impose more strict nondisclosure requirements.

Uses and Disclosures to Which You Have an Opportunity to Object. You will have the opportunity to object to these types of uses and disclosures of PHI that CGHS may make:

Patient Directories. Unless you object, CGHS may use some of your PHI for a directory of individuals in its facility. This information may include your name, your location in the facility, your general condition (*e.g.*, fair, stable, etc.), and your religious affiliation. The information also may be disclosed to members of the clergy or (except for your religious affiliation) to other persons who ask for you by name.

Disclosures to Individuals Involved in Your Health Care or Payment for Your Health Care. Unless you object, CGHS may release 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. CGHS also may notify those people about your location or condition.

Other Uses and Disclosures of PHI for Which Authorization is Required. Authorization is required for: (1) most uses and disclosures of psychotherapy notes (2) uses and disclosures of PHI for marketing purposes; and (3) disclosures that constitute a sale of PHI. In addition, other types of uses and disclosures of your PHI not described above will be made only with your written authorization, which with some limitations you have the right to revoke in writing.

Regulatory Requirements. CGHS is required by law to keep your PHI private, to provide individuals with notice of its legal duties and privacy practices with respect to PHI, and to abide by the terms described in this Notice. CGHS reserves the right to change the terms of this Notice and of its privacy policies, and to make the new terms applicable to all of the PHI it maintains. Before CGHS makes an important change to its privacy policies, it will promptly revise this Notice and post a new Notice in all CGHS public access areas. You have the following rights regarding your PHI:

Restrictions and Communications of PHI

You may request that CGHS restrict the use and disclosure of your PHI. CGHS is not required to agree to any restrictions you request, but if CGHS does so it will be bound by the restrictions to which it agrees except in emergency situations.

You have the right to request that communications of PHI to you from CGHS be made by particular means or at particular locations. For instance, you might request that communications be made to your work address, or by e-mail rather than regular mail. You may also restrict certain disclosures of PHI to a health plan where you pay out of pocket in full for the healthcare item or service. Your requests must be made in writing and sent to:

Health Information Management
777 Hemlock Street
Hospital Box 148
Macon, GA 31201

CGHS will agree to your reasonable requests without requiring you to provide a reason for your request.

Breach Notification

You have the legal right to receive notice, and will receive notice from CGHS, in the event of a breach of your unsecured PHI.

Inspect and Copy PHI

Generally, you have the right to inspect and copy your PHI that CGHS maintains, provided that you make your request in writing to:

Health Information Management
777 Hemlock Street
Hospital Box 148
Macon, GA 31201

Within thirty (30) days of receiving your request (unless extended by an additional thirty (30) days), CGHS will inform you of the extent to which your request has or has not been granted. In some cases, CGHS may provide you a summary of the PHI you request if you agree in advance to such a summary and any associated fees. If you request copies of your PHI or agree to a summary of your PHI, CGHS may charge a reasonable fee to cover copying, postage, and related costs. If CGHS denies access to your PHI, it will explain the basis for the denial and your opportunity to have your request and the denial reviewed by a licensed health care professional (who was not involved in the initial denial decision) designated as a reviewing official. If CGHS does not maintain the PHI you request, but knows where it is located, it will tell you whom to contact.

Correct or Supplement PHI

If you believe that your PHI maintained by CGHS contains an error or needs to be updated, you have the right to request that CGHS correct or supplement your PHI. Your request must be made in writing to:

Health Information Management
777 Hemlock Street
Hospital Box 148
Macon, GA 31201

and it must explain why you are requesting an amendment to your PHI. Within sixty (60) days of receiving your request (unless extended by an additional thirty (30) days), CGHS will inform you of the extent to which your request has or has not been granted. CGHS generally can deny your request if it relates to PHI: (i) not created by CGHS; (ii) that is not part of the records CGHS maintains; (iii) that is not subject to being inspected by you; or (iv) that is accurate and complete. If your request is denied, CGHS will provide 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 CGHS'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 the disclosures of the PHI CGHS has made at any time during the six (6) years prior to the date of your request (provided that such a list would not include releases made prior to April 14, 2003). The list will not include disclosure for which you have provided a written authorization, and does not include certain uses and disclosures to which this Notice already applies, such as those: (i) for treatment, payment, and health care operations; (ii) made to you; (iii) for CGHS's patient directory or to persons involved in your health care; (iv) for national security or intelligence purposes; or (v) to correctional institutions or law enforcement officials.

You should submit any such request to:

Health Information Management
777 Hemlock Street
Hospital Box 148
Macon, GA 31201

and within sixty (60) days of receiving your request (unless extended by an additional thirty (30) days), CGHS will respond to you regarding the status of your request. CGHS will provide the list to you at no charge, but if you ask for more than one request in a year you will be charged a fee of $25 for each additional request. 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 receive a copy of this notice at our Web site, [www.mccg.org]. To obtain a paper copy of this Notice, please contact:

Health Information Management
777 Hemlock Street
Hospital Box 148
Macon, GA 31201

You may complain to CGHS if you believe your privacy rights with respect to your PHI have been violated by contacting CGHS Public Relations at 478-633-1353 and submitting a written complaint to:

Public Relations
777 Hemlock Street
Hospital Box 153
Macon, GA 31201

CGHS will not penalize you or retaliate against you for filing a complaint regarding CGHS's privacy practices. You also have the right to file a complaint with the Secretary of the Department of Health and Human Services.

Incidental Disclosures

Although CGHS trains its staff in appropriate privacy measures, due to the nature of the way treatment and billing occurs within Health System facilities, your medical or billing information may be overheard or seen by people or entities not involved directly in your care. For example, your visitors, or visitors of other patients on your treatment floor could inadvertently overhear a conversation about you or witness a treatment episode. These types of situations are unavoidable.

Business Associates

Your medical or billing information could be disclosed to persons or companies ("vendors") outside the Health System who are under contract with CGHS or others to provide certain services to you and/or to CGHS. CGHS requires these vendors to sign special confidentiality agreements before giving them access to your information. They are also subject to penalties by the federal government if they use/disclose your information in a way that is not allowed by law.

If you have any questions about this Notice, please contact the CGHS Corporate Compliance Office at 478-633-6831.