Bon Secours
Medical Group

Place patient label inside box (if no patient label, complete below)

Name: _____

DOB: _____

MR #: _____

PRACTICE NAME: _____

PATIENT INFORMATION

PATIENT NAME: _____
Last First Middle

HOME ADDRESS: _____

ZIP CODE: _____ CITY: _____ STATE: _____

MAILING ADDRESS: (☐ same as above) _____

ZIP CODE: _____ CITY: _____ STATE: _____

HOME PHONE: (____)_____ WORK PHONE: (____)_____ CELL PHONE: (____)_____

DATE OF BIRTH: _____ SOCIAL SECURITY NUMBER: _____

MARITAL STATUS: _____ CONTACT PREFERENCE: _____

GENDER: _____ RACE: _____ ETHNICITY: _____

LANGUAGE: _____ RELIGIOUS PREFERENCE: _____

PRIMARY CARE PHYSICIAN: _____ REFERRED BY: _____

EMPLOYER: _____ PHONE #: (____)_____

EMAIL: _____ ☐ No E-Mail ☐ Declines to Provide

HOW DID YOU HEAR ABOUT US? _____

GUARANTOR INFORMATION *(name of person to whom financial statements are sent)*

GUARANTOR NAME: _____
Last First Middle

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME PHONE: (____)_____ DATE OF BIRTH: _____ SOCIAL SECURITY NUMBER: _____

INSURANCE POLICY INFORMATION

PATIENT RELATIONSHIP TO POLICY HOLDER: (circle one) SELF SPOUSE CHILD OTHER

PRIMARY POLICY HOLDER DATE OF BIRTH: _____

SECONDARY PATIENT RELATIONSHIP TO POLICY HOLDER: (circle one) SELF SPOUSE CHILD OTHER

SECONDARY POLICY HOLDER DATE OF BIRTH: _____

EMERGENCY CONTACT INFORMATION

NAME: _____ RELATIONSHIP: _____

HOME PHONE: (_____)_____ CELL PHONE: (_____)_____

PATIENT OR LEGAL
REPRESENTATIVE SIGNATURE: _____ DATE: _____

BON SECOURS MEDICAL GROUP
Bon Secours Virginia Health System

Permission to Disclose Private Health Information (PHI)

Patient Name:_____DOB: _____

By signing this paper below, I give permission to the person(s) listed in the table documented to receive Private Health Information or other authorization as listed in the comments section. I understand this form is legally binding and that I may revoke my authorization at any time by submitting by request to change, add, or terminate such permission in writing.

Date of Permission	Name of Individual	Comments/Instructions (i.e.; may pick up meds)	Parent/ Guardian Initials	Date Permission Revoked	Parent/ Guardian Initials	Telephone Number

In order to obtain information by telephone, the party calling the practice must be able to share the patient identifier/password with the staff.

Patient Identifier/Password:_____

Signature of Patient or Legal Guardian_____Date _____ Time_____

Printed Name of Patient or Legal Guardian_____Relationship (if not self) _____

BON SECOURS MERCY HEALTH

BSMH Patient Agreement

This agreement cannot be modified. Any handwritten changes shall not be legally binding or enforceable.

This BSMH Patient Agreement ("Agreement") applies to services rendered at or through all Bon Secours Mercy Health, Inc.-owned or affiliated entities in the United States, including hospitals, physician and provider offices, ambulatory surgery centers, laboratories, telehealth programs, clinics, urgent care centers, freestanding emergency departments, imaging centers and other health care facilities (together, "BSMH"). A list of those entities is located at https://www.bonsecours.com/patient-resources/your-privacy-and-hipaa and at https://www.mercy.com/patient-resources/your-privacy-and-hipaa and each may be updated from time to time.

Consent to Medical Examination, Care & Treatment; Telehealth: I acknowledge that I am seeking medical care, a health care screening and/or other appropriate treatment to be rendered through one or more health care providers employed by or affiliated with BSMH. I voluntarily consent to and authorize the following, as applicable: (i) a physical and/or mental examination; (ii) administration of diagnostic procedures; (iii) rendering of medical care and treatment to me; (iv) laboratory testing; (v) toxicology screening; (vi) radiological procedures; (vii) administration of medications; (viii) follow-up care; (ix) education on my health condition; and (x) all other related care and treatment, as is deemed necessary and advisable by my health care provider(s) with BSMH (together, "Care"). I understand that there are risks of injury from Care. I understand that the practice of medicine is not an exact science, and that no guarantees have been made to me about the results or outcomes of my Care. I understand that I may request additional information regarding any recommended Care and that BSMH, or health care providers with BSMH, may obtain additional written consent from me for more complex Care, such as surgery. I understand that BSMH may adopt modified operations during a period of crisis or emergency made necessary by a pervasive (such as a pandemic) or catastrophic (such as a hurricane or tornado) disaster.

I understand that I may receive Care from BSMH on an in-person basis or through an electronic virtual platform that is generally referred to as "Telehealth." Telehealth involves the delivery of Care using electronic communications, information technology and/or other means (such as a wearable monitor) between a health care provider and a patient who are not located in the same place at the time Care is being provided.

I understand that in the case of Care provided in-person and provided via Telehealth, while there are benefits, there are also some risks, including, but not limited to: (a) my health care provider may advise me to seek urgent or emergency care services; (b) my health care provider may determine I need to be examined in person and may recommend – possibly after consulting with another clinician – that I may need to seek Care from a specialist or other healthcare provider; (c) my health care provider may be able to provide preliminary diagnose and treatment; however, to complete a diagnosis, I may be advised to obtain follow up Care, including an in-person visit; and (d) given regulatory requirements in certain jurisdictions, my health care provider's ability to prescribe certain Care options (e.g., certain controlled substance prescriptions) may be limited. Further, I acknowledge that the electronic systems or other security protocols or safeguards used in Telehealth could fail, which could expose my health and/or other personal information to unauthorized individuals, even if BSMH uses HIPAA-compliant, secure technology platform(s). I understand my connection with my health care provider may fail and we may have to re-engage in the encounter. I understand my Telehealth visit will not be recorded without my express consent. I understand that I can opt out of a Telehealth visit in favor of an in-person visit and that I may request information regarding my Telehealth provider's credentials, training and qualifications.

Medical Education Programs: I acknowledge that among those who attend to my Care at BSMH may be health care personnel who are currently in professional education or training programs, including: medical students, physician residents, nursing students, etc. All students and resident physicians are supervised by licensed and trained health care providers, as appropriate, and I consent to Care provided by them. Unless otherwise requested by me, these students and resident physicians may be present and participate in my Care as a part of their education or training.

Affiliated Providers/Independent Contractors/Non-Employed Providers: I understand that many of the health care providers with BSMH, possibly including my attending and/or consulting physicians, are not employees or agents of BSMH but, rather, are independent contractors who have been granted the privilege of using one or more BSMH locations for the Care of patients. I understand that the actions or inactions of any health care provider who is not an agent or employee of BSMH is not directed or controlled by BSMH and that BSMH relies upon such health care provider(s) to use appropriate professional judgment in providing Care to me at BSMH. I agree that BSMH is not responsible for the acts or omissions of any health care provider who is not an agent or employee of BSMH.

Affiliated Provider Fees: I understand that BSMH's hospital and facility charges for my Care may not include the fees

of health care providers who provided Care to me but who are not agents or employees of BSMH. I understand that I may receive a separate bill for my Care directly from such provider(s), including but not limited to, emergency department physicians, radiologists, pathologists, anesthesiologists, hospitalists, other specialists, etc. I understand that the level of insurance benefits payable for Care by health care providers who are not agents or employees of BSMH may be different from the level of insurance benefits payable for Care rendered through BSMH.

Left Without Being Seen; Non-Compliance with Care Plan: If I leave BSMH before a health care provider with BSMH has seen me or discharged me, or if I refuse to comply with my prescribed plan of care, I agree that I assume the full responsibility for this action and hold BSMH, its employees, and agents separately and individually harmless from any and all liability or harm as a direct or indirect result of my failure to be treated, my refusal to comply, and/or my departure from BSMH, and I will waive any and all rights and causes of action that I may now have or later acquire against BSMH, its employees, and agents as a direct or indirect result of any of the foregoing.

Uses/Access/Disclosure of My Health Information: I authorize BSMH, its duly authorized agents and affiliates to use and to disclose my individually identifiable information, including information about my Care, with other health care providers and facilities, both at BSMH and outside BSMH, who are involved in my Care, including for the purpose of coordinating my Care. I authorize BSMH to release my individually identifiable information, including information about my Care located in my BSMH-designated medical record about Care provided to me by BSMH and providers outside BSMH, and other financial and demographic information as required to obtain payment from my insurance or other payer(s) and their agents. I have been provided and/or offered a copy of the BSMH Notice of Privacy Practices which may be updated from time to time on BSMH's websites. I understand that this Notice of Privacy Practices outlines additional, authorized uses and disclosures of my health information by BSMH, as well as my rights to obtain my health information and to further restrict its use or disclosure.

Photography & Video Recordings: I consent to have my photograph taken by BSMH for purposes of confirming identification and for the treatment, payment and health care operations of BSMH. I understand that my Care at BSMH may include obtaining, using, and disclosing photographs, videos, and/or making audio recordings of me for Care-oriented purposes and/or for the health care operations of BSMH, including quality assurance, clinical documentation, education, or other purposes permitted by applicable law. To the extent that any such photography, video, and/or audio recording is included in my BSMH-designated medical record, I understand that BSMH will treat it as protected health information consistent with applicable law. *Notwithstanding the foregoing, I understand that I have the option at any time to decline to be photographed or videoed.*

Communications: I authorize BSMH, its agents and contractors (e.g., a billing company) to communicate with me directly by phone or by e-mail, text message and/or other forms of electronic communication that may be encrypted (together, "Electronic Messaging"). I understand that these authorized individuals will communicate with me using the phone number(s) and email(s) that I provide to BSMH. *Notwithstanding the foregoing, I understand that, at any time, I can direct BSMH to discontinue any or all Electronic Messaging by communicating my preferences to BSMH.* I further understand that withdrawing this authorization will not cause me to lose any benefits or rights to which I am otherwise entitled, including but not limited to, continued Care, payment options, enrollment or eligibility for programs/benefits offered by BSMH, etc.

I understand that authorized individuals may use Electronic Messaging to communicate with me regarding a wide range of healthcare-related issues, including: reminders of appointments; actions for me to take before an appointment; follow-ups from appointments; notices about preventive services, Care options, coordination of my Care and other available health care services; how to participate in patient satisfaction surveys; how to use BSMH's secure patient portal (MyChart); information regarding insurance, billing, eligibility for programs/benefits and account balances, etc. I understand that BSMH may use automatic dialers or pre-recorded voice messages when it communicates with me through Electronic Messaging.

I understand that BSMH cannot guarantee, but will use reasonable means to maintain, the security and confidentiality of Electronic Messaging. I consent to the use of Electronic Messaging upon the following conditions: (1) **IN A MEDICAL EMERGENCY, DO NOT USE ELECTRONIC MESSAGING, CALL 911**; (2) Urgent messages or needs should be relayed to BSMH by telephone call; (3) Non-urgent messages or needs should be relayed to BSMH by telephone call or BSMH's secure patient portal, MyChart; (4) Electronic Messaging may be made a part of my BSMH-designated medical record; (5) BSMH, its employees, and agents are not liable to me for any breach of confidentiality caused by me or any third party; and

(6) I am solely responsible for any charges or other fees incurred under my agreement with my Electronic Messaging service provider (e.g., per minute, per message, per unit-of-data-received basis, etc.).

In consideration of BSMH's services and my authorization to receive Electronic Messaging as described in this Agreement, I release BSMH, its employees and agents from any and all claims resulting directly or indirectly from the Electronic Messaging, including any claims based on any alleged violation of applicable law (including the Telephone Consumer Protection Act, the Truth in Caller ID Act, the CAN-SPAM Act, the Fair Debt Collection Practices Act, the Fair Credit Reporting Act, the Health Insurance Portability and Accountability Act, any similar state and local acts or statutes, any federal or state tort or consumer protection laws, etc.).

Responsibility for Payment; Emergency Care: I understand that a list of BSMH's usual and customary charges for its health care services is available to me upon request. If I choose to pay for certain of these services out-of-pocket (i.e., self-pay) for the purpose of exercising my right to limit disclosure of my health information to my health insurer regarding those services, I understand that a separate financial agreement will be required regarding the self-pay services.

If I present to a BSMH emergency department seeking, or in need of, emergency medical treatment, I understand that screening and stabilizing treatment for any emergency medical condition will not be delayed or conditioned upon my ability to pay, method of payment, or my coverage status.

I understand that I am responsible for any amounts due for my Care that are not paid by my health insurer or any other applicable insurance plan, policy, or third party. Such amounts due may include, but are not limited to, deductibles, copays, and coinsurance amounts provided under any coverage source, charges for which there is no coverage source, etc. I understand and agree that I am ultimately responsible for any cost of my Care that is not covered by my insurance or other third party. I understand that I am responsible for any unpaid balances due, plus the reasonable costs of collections, including any attorney fees and court costs associated with collecting an unpaid portion of the bill.

Financial Agreements; Insurers & Third-Party Payers; Assignment of Benefits; Authorized Representative; Agent: If applicable, I certify that any information given by me in applying for payment under the Medicare or Medicaid Programs is correct. I assign to BSMH all rights to benefits, covered payments, insurance reimbursements or other payments to which I may be entitled for Care provided to me at BSMH. I authorize BSMH to bill my insurance or any other responsible party(ies) and assign the payment of these benefits directly to BSMH.

I assign all rights to benefits, insurance payments, insurance reimbursements or other payments or judgments to which I may be entitled for hospital-based physician Care (pathology, radiology, cardiology, etc.) and emergency department Care to the physician or organization providing the professional Care. I also authorize submission of a bill(s) for professional Care provided to me through BSMH to my insurance or any other responsible party(ies) for payment.

I authorize and designate BSMH (including any third parties who perform retrospective reviews, denial and audit work) as my authorized agent(s) and designated representative(s) with the power to act on my behalf with respect to all matters related to all of my rights, benefits, privileges, protections, claims, causes of action, interests or recovery arising out of any coverage source, including but not limited to, the ability to request reconsideration and/or appeal payment decisions made by any group health plan, employee benefits plan, health insurance plan, any other applicable insurance plan or utilization review entity for coverage or grievance review (the "Plan"), etc. This includes, without limitation, the authority and right to: file medical claims with the Plan; file appeals and grievances with the Plan; request verification of coverage or pre-certification or authorization; file pre-service and post-service claims; request any and all information and documents under which the Plan is established or operated; request any and all policies, procedures and guidelines and protocols considered by the Plan in connection with the benefit claim determination; and to institute any alternative dispute proceedings, litigation and/or complaints against the Plan naming me as the plaintiff in such proceedings if necessary. I further designate and authorize BSMH to the fullest extent permissible under law the right and ability to act as my representative with respect to any ERISA-governed benefit plans as provided in federal regulations with respect to any healthcare expense incurred as a result of the Care I received at BSMH. This authorization is applicable in the same manner as the other grants of authority conveyed within this paragraph, but I recognize they may be brought pursuant to federal ERISA regulations and case law. Similar to the provision in this paragraph, I recognize BSMH may assert any rights I may have under the plan even to name me as a plaintiff in an action against the plan. I understand I can revoke this authorization in writing at any time.

I acknowledge that BSMH reserves the right to file a lien where appropriate and permitted by applicable law.

I understand that if BSMH is not in contract with my plan or other coverage, there will likely be a balance due to me that is in excess of any co-pays, co-insurance or deductibles. I also agree that any attempt by a benefits coverage source to preclude BSMH from the ability to appeal a claim, to prevent balance billing if allowable by applicable law, or to disallow BSMH's right to take action by assignment, will not be acknowledged.

Although I previously acknowledged that BSMH reserves the right to receive payment from all applicable sources, I specifically authorize BSMH to pursue any and all applicable insurance(s) covering motor vehicle accidents as well as workers' compensation claims, and I agree to cooperate with BSMH by providing information and by completing any form(s) that BSMH may ask me to execute from time to time.

Finally, I understand that a health care provider with BSMH may order services, testing, items, or other Care that require pre-approval from my insurer or third-party payer before I receive such services, testing, items, and/or other Care. I agree to cooperate, aid and assist BSMH in obtaining all such approvals and possible insurance or other benefits for such services, testing, items, and/or Care (e.g., completing an application for insurance, providing timely information as requested, etc.).

Credit Balance Transfer: When a non-governmental credit balance exists on a BSMH account in an amount not exceeding $10.00, I agree that BSMH may adjust that balance to zero without investigation for overpayment, or improper/excess payment made to a practice/provider as a result of patient billing, or claims processing errors.

Pharmacy Benefit Programs: I understand that if I cannot afford medication prescribed to me during my Care at BSMH, or if that medication is not covered by my insurance, BSMH may be able to obtain reimbursement for certain medications through one or more Patient Assistance Programs sponsored by drug manufacturers. To qualify for the Program(s), it may be necessary to provide information regarding my financial status, illness, and/or treatment to the drug manufacturer sponsoring the Program(s). All information associated with these Programs will remain confidential and will only be provided to drug manufacturers in compliance with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and other applicable law. My signature on this form authorizes BSMH and its authorized representatives to complete any necessary application forms. I release any claim to the medication I may receive as a result of my participation in the Program(s) and give my permission for any medication to be repackaged. This authorization shall remain in full force from the date signed, below, until I revoke it or until I no longer belong to any Programs, whichever occurs earlier.

BSMH Packet of Patient Information: I understand that BSMH offers Financial Assistance to those that meet certain eligibility criteria outlined in BSMH's Healthcare Financial Assistance ("HFA") Policy and that a copy of the Plain Language Summary of BSMH's HFA Policy is available upon request. I confirm that I am aware of the HFA Policy and that a copy of the Plain Language Summary has been offered to me. I agree that if I make an application for this Financial Assistance, BSMH is permitted to request, use, and disclose information as necessary to determine whether I am eligible for Financial Assistance.

I agree to comply with all guidelines, policies and procedures I may receive from BSMH at the time of my Care. I understand that information on BSMH's HFA Policy and its Plain Language Summary enumerate certain rights afforded to me as a patient and are consistent with the BSMH Code of Conduct. I acknowledge that I have received other documentation required by law in my packet of patient information, including Patient Rights & Responsibilities documentation, if appropriate.

Responsibility for Valuables/Personal Property: I understand and agree that BSMH is not responsible for safeguarding my personal property or any other personal item. I agree to waive any and all rights and causes of action that I may now have or later acquire against BSMH, its employees, and agents as a direct or indirect result of any loss, theft, or damage to such property or item, including: jewelry, clothing, money, hearing aids, glasses, dentures, dental work, electronics, vehicles, etc. BSMH recommends that I leave my valuables at home or with a family member or friend.

Statement of Non-Discrimination: BSMH complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, ethnicity, religion, sex or sexual identification, national origin, sexual orientation, age, ancestry, disability, veteran era status, or any person with HIV infection, whether asymptomatic or symptomatic, or AIDS, in any other manner prohibited by applicable State or Federal law, or in the treatment of patients. BSMH does not exclude people or treat them differently because of race, color, ethnicity, religion, sex, national origin, sexual orientation, age, ancestry, disability, veteran

era status, or any person with HIV infection, whether asymptomatic or symptomatic, or AIDS, or in any other manner prohibited by applicable State or Federal law.

****

BY SIGNING BELOW, I CONFIRM ALL THE FOLLOWING: I have read this Agreement or have had it effectively communicated to me; any questions I may have had about this Agreement have been asked and answered to my satisfaction; I acknowledge that a separate consent or agreement may be required prior to receiving certain Care with BSMH; I understand and accept all the terms and conditions of this Agreement; I am the patient or his/her duly authorized personal representative; and I am signing this Agreement voluntarily.

_____	**OR**	_____
Signature of Patient		Signature of Personal Representative
Date & Time: _____		Date & Time: _____
_____		_____
Patient Printed Name		Personal Representative Printed Name

BON SECOURS MERCY HEALTH

PLAIN LANGUAGE SUMMARY OF HEALTHCARE FINANCIAL ASSISTANCE POLICY

Overview

In with the light of its mission to improve the health of its communities, with special emphasis on the poor and underserved, and in the spirit of the healing ministry of Jesus, Bon Secours Mercy Health is committed to providing financial assistance to its patients. This is a summary of the Bon Secours Mercy Health Healthcare Financial Assistance (HFA) Policy.

Availability of Financial Assistance

Eligibility for financial assistance is determined by the ability of the patient or his/her guarantor to pay after all available resources have been utilized and all available assistance programs have been assessed. Financial assistance is available for emergency and other medically necessary care provided by Bon Secours Mercy Health hospitals (and certain other providers) to uninsured and underinsured patients who live in the community served by a Bon Secours Mercy Health hospital, and whose family income does not exceed four times the Federal Poverty Guidelines (FPG).

Eligibility Requirements

Financial assistance is generally determined by a sliding scale of total household income based on the FPG. Individuals eligible for financial assistance under our Policy with an income level at 200% FPG or below receive free care. Individuals with an income level from 201% to 300% FPG, and 301% to 400% FPG, respectively, receive discounted care based on a sliding scale, as set forth in the Policy. The specific percentage discounts for the 201%-300% FPG, and 301% to 400% FPG, income levels are updated annually for each market commensurate with changes in the charge master.

No person eligible for financial assistance under the HFA policy will be charged more for emergency or other medically necessary care than amounts generally billed to individuals who have insurance covering such care. If an individual has sufficient insurance coverage or assets available to pay for care, he/she may be deemed ineligible for financial assistance. For those uninsured patients who do not qualify for any of the financial assistance discounts described in the HFA policy, Bon Secours Mercy Health extends an automatic (selfpay) discount to their hospital bills. Please refer to the full HFA Policy for a complete explanation.

About the Application Process

The process for applying for financial assistance under our HFA Policy includes these steps:

- Complete the HFA Application Form and include required supporting documents.
    - We look at your income and family size to determine the level of assistance available to you. We use a sliding scale, based on FPG outlined above.
    - We require that you must first explore eligibility for some type of insurance benefits that would cover your care (i.e. worker's compensation, automobile insurance, etc.) We can help direct you to the appropriate resources.
- We will contact you to tell you whether you are eligible for financial assistance under our HFA Policy.
- We can help you arrange a payment plan for any remaining charges or bills that are not covered under our HFA Policy.
    - A payment plan will consider your financial situation to set payments that you can manage.

Where to Obtain Information

You may obtain a copy of our HFA Policy and the HFA Application Form, as well as information about the financial assistance application process: (i) by visiting our website at www.bsmhealth.org/financial-assistance, www.mercy.com/financial-assistance, and www.fa.bonsecours.com, (ii) by contacting Bon Secours Mercy Health Patient Financial Services by telephone at 1-877-918-5400, (iii) by mailing a request to Bon Secours Mercy Health, 11511 Reed Hartmann Highway, Blue Ash, OH 45241, Attn: Financial Counseling, or (iv) by contacting our financial counselors in person at any of our hospital locations (see the full HFA Policy for a complete listing of facilities and addresses).

We accommodate all significant populations served by Bon Secours Mercy Health that have limited proficiency in English by translating copies of our HFA Policy, Application Form, and this Summary in the primary languages spoken by those populations. We may also elect to furnish translation aids, translation guides, or provide assistance through use of qualified bilingual interpreters.

BON SECOURS MERCY HEALTH

Language Interpreters

Bon Secours Mercy Health, Inc. ("BSMH") provides free aids and services to people with disabilities to communicate effectively with us such as:

- Qualified sign language interpreters
- Written information in other formats (large print, Braille, audio, accessible electronic formats, other formats)

You can contact the person at the registration desk to receive information on how to obtain the free aids and services for persons with disabilities or access the interpretation services.

All patients have access to interpretation services 24/7 at no personal cost to them.

- lHabla espanol? Le proporcionaremos un interprete sin costo alguno para usted. (Spanish)
- 您讲国语吗？我们将免费为您提供 翻译 (Mandarin)
- Sprechen Sie Deutsch? Wir stellen Ihnen unentgeltlich einen Dolmetscher zur Verfogung. (German)
- هل تتحدث اللغة العربية؟ سوف نوفر لك مترجمًا فوريًا بدون أي تكلفة عليك. (Arabic)
- Bbl l'OBOp1ne rro-pycCKH? Mbl a6comOTHO 6ecmraTHO rrpeJ:IOCTaBHM BaM rrepeBO,[(Y.HKa. (Russian)
- Parlez-vous fram;ais? Nous vous fournirons gratuitement un interprete. (French)
- Quy vi n6i duQ'c ti@ng Vi t kh6ng? Chung t6i se cung c p mot thong dich vien mi&n phi cho quy vi. (Vietnamese)
- 한국어를 사용하십니까? 무료로 통역 서비스를 제공해 드리겠습니다. (Korean)
- Parla italiano? Le forniremo gratuitamente un interprete. (Italian)
- 日本語を話しますか？ 個人的な負担なしで通訳を提供致します。 (Japanese)
- B11 pmMOBAAeTe yKpai:HChKOIO? M11 a6co11IOTHO 6e3KOIIITOBHO tta):(aMo BaM rrepeKJia):(aY.a. (Ukrainian)
- Vorbiti romane te? Va vom asigura gratis un interpret. (Romanian)

Complaints and Grievances

If you believe BSMH has failed to provide these services or discriminated in another way on the basis listed above, you can file a grievance. BSMH can provide a copy upon request of its grievance filing procedures and contact information for individual(s) who can assist in filing and addressing the grievance.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office of Civil Rights electronically through the Office of Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509 F, HHH Bldg, Washington DC 20201 [1-800-368-1019 or 1-800-537-7697 {TDD}].

Southampton Orthopaedic & Sports Medicine Center

Manish A. Patel, MD, FAAOS

Board Certified – American Board of Orthopaedic Surgeons
Assistant Professor of Clinical Orthopaedic Surgery EVMS
Arthroscopic Surgery – Sports Medicine – Joint Replacement

Phone: 757-562-7301 www.SouthamptonOrtho.com **Fax: 757-562-7305**

New Patient Complaint / Injury

First Name:_____ Last Name:_____ Today's Date:_____

Date of Birth: _____ Age: ____ Height:_____ Weight: _____ Sex: M or F

Please **Circle** affected extremity ONLY: **Left** **Right** **Both**

Shoulder Arm Elbow Forearm Wrist Hand Finger Back
Hip Thigh Knee Leg Ankle Foot Toes Neck

Is Your pain (Circle): Sharp Dull Throbbing Stabbing Burning Numbness **NONE**

How and When did this injury / problem begin? (**Be specific**)

Is your Pain? (Circle One) **Better** **Worse** **Same** compared to your initial pain.

What has helped? | What makes it worse?

Please rate your pain level Using 0 (None) to 10 (Severe) [**0 1 2 3 4 5 6 7 8 9 10**]

Review of Systems:

Musculoskeletal: **Circle** any that apply to you or **Circle NONE**

Fractures Joint Swelling Joint Infections Locking
Stiffness Night Time Pain Instability **NONE**

Constitutional: **Circle** any that apply to you or **Circle NONE**

Weight Gain Weight Loss Fever Chills Fatigue
Weakness Night Sweats Insomnia **NONE**

Is this a Work Related Injury? (Answer Must be Circled) **YES** **NO**
Was this related to a Motor Vehicle Accident? **YES** **NO**
Is there a LAWSUIT involved? (Answer Must be Circled) **YES** **NO**

Have you been treated previously for this problem? **YES** **NO**

Physician: _____ Hospital:_____ City:_____

Circle **ALL** previous testing for the CURRENT problem:

X-ray Cat Scan MRI Physical Therapy DVT Study
Injections Surgery EMG Bone Scan **NONE**

Have you received you COVID 19 Vaccination? YES OR NO Date_____

(PLEASE SIGN) Patient or Guardian Signature _____

First Name: _____ Last Name: _____ Today's Date: _____

Who is your Family Doctor? _____

Please list the consulting Doctor? _____

Do you have any of the following medical conditions? (**Circle** all that apply or **NONE**)

High Blood Pressure	Kidney Disease	Hepatitis
Lung Disease	Asthma	Bleeding Disorder
Sickle Cell	Osteoporosis	Diabetes
Poor Healing	Reflux / Ulcers	Heart Disease / Problems
High Cholesterol	Thyroid Problems	HIV / AIDS
Rheumatoid Arthritis	Osteoarthritis	Gout
Cancer	Blood Clots	Other: _____

Please indicate any major health conditions that your immediate family members have:

Relationship: _____ Medical Condition: _____ Died at age: ____
Relationship: _____ Medical Condition: _____ Died at age: ____
Relationship: _____ Medical Condition: _____ Died at age: ____
Relationship: _____ Medical Condition: _____ Died at age: ____

Please List **ALL** supplements / medications, dosages, and frequencies that you take or **NONE**:

_____

_____

Do you take any blood thinners? NO or YES (List if yes) _____

Do you have any past history of BLOOD CLOTS? YES OR NO

Please list ALL allergies: **NONE** or YES (if yes, list medication and type of reaction):

_____

Please list **ANY** previous surgeries and/or complications **NONE**. (Include date and surgeon):

_____

Smoking Status (Circle one): Never Former Smoker Current Smoker

If current smoker, how many packs a day: _____

Former Smoker Quit Date: _____

Smokeless Tobacco: _____Yes _____No

Do you drink alcohol: _____Yes _____No

If yes, how often? _____

What Pharmacy do you use? _____Location: _____

DEPRESSION SCREENING: MENTAL HEALTH

Do you have little interest or pleasure in doing things? 0=Not at all, 1=Several Days, 2=More than half the days, or 3=Nearly everyday

Are you feeling down, depressed, irritable, or hopeless? 0=Not at all, 1=Several Days 2=More than half the days, or 3=Nearly everyday

BON SECOURS HAMPTON ROADS
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 CAREFEULLY.

Our Pledge Regarding Your Medical Information

Bon Secours Hampton Roads Health System ("Bon Secours Hampton Roads") is committed to protecting medical information about you. We create a record of the medical care and services you receive at Bon Secours Hampton Roads sites for use in your care and treatment. We need this record to provide you with quality care and to comply with certain legal requirements.

This notice applies to all the records of your care relating to services provided in the hospitals, outpatient and ambulatory care centers and other facilities that comprise the Bon Secours Hampton Roads Health System, as well as the physicians and other health care professionals who provide services within those facilities, whether made by employees of Bon Secours or your personal doctor. If your personal doctor is not an employee of Bon Secours Hampton Roads, then your doctor may have different policies or notices regarding how information maintained by the doctor's office or clinic is used or disclosed about you.

This notice tells you about the ways in which we may use and disclose medical information about you. It also describes your rights and certain obligations we have regarding the use and disclosure of your information.

We are required by law to:

- **make sure that your medical information is protected;**
- **give you this Notice describing our legal duties and privacy practices with respect to your medical information; and**
- **follow the terms of the Notice that is currently in effect.**

Who Will Follow This Notice?

This notice describes the practices of Bon Secours Hampton Roads and those of the following individuals and organizations (collectively, "we"):

- All divisions, affiliates, facilities, medical groups, departments and units of Bon Secours Hampton Roads;
- Any member of a volunteer group we allow to help you while you are in a Bon Secours Hampton Roads facility;
- All employees, staff and other Bon Secours Hampton Roads personnel; and

- Bon Secours Hampton Roads-based physicians, physician practices, residents, and medical students, with regard to services provided and medical records kept at a Bon Secours Hampton Roads facility or by physicians employed by or under contract with Bon Secours Hampton Roads.

How We May Use and Disclose Medical Information About You

The following sections describe different ways that we may use and disclose your medical information. For each category of uses or disclosures we will describe them and give some examples. Some information, such as certain genetic information, certain drug and alcohol information, HIV information and mental health information may be entitled to special restrictions by state and federal laws. We abide by all applicable state and federal laws related to the protection of this information. Not every use or disclosure will be listed, but all of the ways we are permitted to use and disclose information will fall within one of the following categories.

Treatment: We may use or disclose medical information about you to provide you with medical treatment or services. We may disclose information about you to doctors, nurses, technicians, students or other personnel involved in taking care of you. For example, a doctor treating you for a broken hip may need to know if you have diabetes so that proper medications, meals and treatments can be ordered. We may share medical information about you with Bon Secours Hampton Roads personnel or other health care providers, agencies, or facilities not affiliated with Bon Secours Hampton Roads in order to provide or coordinate the different things you need, such as prescriptions, lab work, and X-rays. We may also disclose medical information about you to people outside of Bon Secours who may be involved in your continuing medical care after you leave Bon Secours Hampton Roads, such as other health care providers, transport companies, community agencies and family members or others providing services that are part of your care. We may disclose information about your care to any doctor identified as a provider of medical care to you, even if that doctor is not a direct participant in a given episode of care at Bon Secours Hampton Roads. For example, it is routine for Bon Secours Hampton Roads to provide information about your care to your primary care provider (PCP). We may participate in an electronic health information exchange to facilitate the sharing of your medical information for treatment purposes.

Payment: We may use and disclose medical information about you so for payment activities of Bon Secours Hampton Roads and others involved in your care, such as an ambulance company. For example, we may use and disclose information so that Bon Secours or others involved in your care can obtain payment from you, an insurance company or another third party. We may disclose your information to the Social Security Administration, or any other person or insurance or benefit payor, health care service plan or worker's compensation carrier which is, or may be responsible for all or part of your bill. For example, we may give your insurance company information about surgery you receive at Bon Secours so they will pay us or reimburse you for the surgery. We may tell your insurance company about a proposed treatment to determine whether or not they will pay for the treatment or to resolve an appeal or complaint/grievance. However, if you pay in in cash in advance for your treatment, and you ask us not to disclose your health information to your insurance company with regard to that treatment, we will honor your request.

Health Care Operations: We may use and disclose medical information about you for our health care operations and for certain health care operations of other providers who furnish care to you. These uses and disclosures are necessary to operate Bon Secours Hampton Roads and to make sure that all of our patients receive quality services. For example, we may use medical information to review our treatment and services, to evaluate the performance of our staff, and to survey you on your satisfaction with our treatment and/or services. We may review and/or aggregate medical information to decide what additional services or health benefits Bon Secours should offer, what services are not needed, and whether certain new treatments are effective. We may disclose

information to doctors, nurses, technicians, students training with Bon Secours, and other Bon Secours personnel for review and learning purposes. We may combine the medical information we have with medical information from other health care entities to compare how we are doing and see where we can make improvements in the care and services we offer. Bon Secours may disclose information to private accreditation organizations, such as the Joint Commission, in order to obtain accreditation from these organizations.

Health Information Exchange (HIE): Bon Secours Hampton Roads participates in the Med Virginia Health Information Exchange (HIE), a secure internet-based "virtual" health record. The HIE is an organization in which providers, such as doctors and other health care providers, participate to exchange patient information in order to facilitate health care. By participating in the HIE, we may share certain portions of your health information with other providers that participate in the HIE or participants of other health information exchanges.

The virtual health record contains lab results, transcription reports, radiology results, medical history, transcriptions and chart notes, insurance information and demographic information from all of your health care providers who participate in the HIE. There are some types of information that are subject to an additional layer of security within the HIE. Examples of such information may include certain drug and alcohol abuse information and HIV test results. Items that are subject to the additional security may not be readily viewable in the HIE's standard electronic chart.

Unless you notify Bon Secours Hampton Roads that you do not wish for your health information to be available through the HIE ("Opt Out"), we may include your information in the HIE.

If you Opt-Out, your health information will no longer be accessible by other providers through the HIE. However, your Opt-Out does not affect health information that was disclosed through the HIE prior to the time that you opted out and your information may still be used and disclosed through other means, such as providing a paper copy.

Regardless of whether you choose to opt-out of the HIE, your health information will still be provided to the HIE. However, if you choose to Opt-Out, the HIE will not exchange your health information with other providers. Additionally, you cannot choose to have only certain providers access your health information.

All providers who participate in the HIE who provide services to you will have the ability to access to your information. However, participating providers that do not provide services to you will not have access to your information through the HIE.

Information available through the HIE may be provided to others as necessary for referral, consultation, treatment and/or the provision of other treatment-related healthcare services to you. This includes providers, pharmacies, laboratories, etc.

You may Opt-Out at any time by notifying the Bon Secours Hampton Roads Privacy Officer. The Privacy Officer's contact information is found at the end of this notice.

Business Associates: We may share your medical information with third-parties referred to as "business associates". Business associates provide various services to or for Bon Secours. Examples include billing services, transcription services and legal services. We require our business associates to sign an agreement requiring them to protect your information and to use it only for the purposes for which we have contracted for their services in an effort to make sure your medical information is appropriately safeguarded.

Fundraising Activities: We may contact you to provide information about Bon Secours Hampton Roads-sponsored activities, including fund-raising programs and events. You may request to "opt out" of fund raising communications if you do not wish to be contacted.

Hospital Directory (Hospital Only): If you are hospitalized, we may include your name, location in the hospital (for example: room number or emergency room), your general condition (for example: fair condition, stable condition, etc.) and your religious affiliations in the hospital directory. The directory information, except for your religious affiliation, may be released to people who ask for you by name so your family, friends and clergy can visit you in the hospital and generally know how you are doing. Your religious affiliation and directory information may be given to members of the clergy, such as priests, ministers, or rabbis even if they don't ask for you by name. If you object to any or all of this information being included in the hospital directory, you must tell your caregivers at Bon Secours Hampton Roads so that information about you may be removed from the directory.

Individuals Involved in Your Care or Payment for Your Care: Unless you tell us not to, we may release medical information to anyone involved in your medical care, such as a friend, family member, or any individual you identify. We also may give your information to someone who helps pay for your care. Additionally, we may disclose information about you to your legal representative. If a person has the authority by law to make healthcare decisions for you, Bon Secours Hampton Roads typically will treat that legal representative the same way we would treat you with respect to your medical information. Parents and legal guardians are generally patient representatives of minors unless the minors are permitted by law to act on their own behalf and make their own medical decisions in certain circumstances.

Research: We may use and disclose medical information about you for certain research purposes in compliance with the requirements of applicable federal and state laws. All research projects, however, are subject to a special approval process, which establishes protocols to ensure that your health information will continue to be protected. When required, we will obtain a written authorization from you prior to using your health information for research.

As Required or Authorized by Law: We will disclose medical information about you when required to do so by federal and/or state law. This includes, but is not limited to, disclosures to mandated patient registries, including reporting adverse events with medical devices, food, or prescription drugs to the FDA. We also may disclose medical information to health oversight agencies for activities authorized by law. These oversight activities may include licensure activities and other activities by governmental, licensing, auditing and accrediting agencies as authorized or required by law. We may disclose your health information for public health activities including disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; or notify a person who may have been exposed to a disease or condition. We may disclose information for law enforcement purposes as required by law or in response to a valid subpoena, summons, court order, or similar process.

Legal Proceedings, Lawsuits and Other Legal Actions: We may disclose medical information about you to courts, attorneys, court employees and others when we get a court order, subpoena, discovery request, warrant, summons or other lawful instructions. We also may disclose information about you to Bon Secours' attorneys and/or attorneys working on Bon Secours' behalf to defend ourselves against a lawsuit or action brought against us.

We may use and disclose your medical information in the following special situations:

- **Disaster-Relief Efforts**: We may disclose medical information about you to an organization assisting in a disaster-relief effort so that your family can be notified about your condition, status and location. If you do not want us to disclose your medical information for this purpose, you must tell your caregivers so that we do not disclose this information unless we must do so to respond to the emergency.
- **To Avert a Serious Threat to Health or Safety**: We may use and disclose medical information about you to help prevent a serious and imminent threat to your health and safety or the health and safety of the public or another person.
- **Organ, Eye and Tissue Donation**: We may release information to organizations that handle organ procurement, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.
- **Military**: If you are a member of the armed forces, domestic (United States) or foreign we may release medical information about you to the military authorities as authorized or required by law.
- **Workers' Compensation**: We may disclose medical information about you for workers' compensation or similar programs as authorized or required by law.
- **Coroners, Medical Examiners and Funeral Directors**: We may disclose medical information to a coroner, medical examiner or funeral director as necessary for them to carry out their duties.
- **National Security and Intelligence Activities**: We may disclose medical information about you to authorized federal officials for intelligence, counterintelligence and other national security activities as required by law.
- **Protective Services for the President of the United States and Others**: We may disclose medical information about you to authorized federal officials so they may conduct special investigations or provide protection to the President of the United States, other authorized persons or foreign heads of state as authorized by law.
- **Inmates**: If you are an inmate of a correctional institution or under the custody of law enforcement officials, we may release medical information about you to the correctional institution or law enforcement officials as authorized or required by law.

Uses of Medical Information Requiring Authorization

Psychotheraphy Notes: We must obtain your written permission to disclose psychotherapy notes except in certain circumstances. For example, written permission is not required for use of those notes by the author of the notes with respect to your treatment, or use or disclosure by us for training of mental health practitioners, or to defend Bon Secours Hampton Roads in a legal action brought by you.

Marketing: We must obtain your written permission to use or disclose your medical information for marketing purposes except in certain circumstances. For example, written permission is not required for face-to-face encounters involving marketing, or where we are providing a gift of nominal value (example: a coffee mug), or a communication about our own services or products (example: we may send you a postcard announcing the arrival of a new surgeon or x-ray machine).

Sale of PHI: We must obtain your written permission to disclose your medical information in exchange for remuneration.

Other Uses and Disclosures: Other Uses and Disclosures of your PHI not covered by the categories included in this Notice or applicable laws, rules or regulations will be made only with your written permission or authorization. If

you provide us with such written permission, you may revoke it at any time. We are not able to take back any Uses or Disclosures that we already made with your authorization. We are required to retain your medical information regarding the care and treatment that we provided to you.

Your Rights Regarding Medical Information About You

You have the following rights regarding your medical information:

Right to Inspect and Copy: With certain exceptions, you have the right to inspect and/or receive a copy of your medical and billing records or any other of our records that are used by us to make decisions about your care. The exceptions to this are any psychotherapy notes, information collected for certain legal proceedings and any medical information restricted by law.

To inspect and or receive a copy of your medical records we require that you submit your request in writing to your Bon Secours Hampton Roads care provider or the appropriate medical records department. If you request a copy of your medical records, we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. Under certain circumstances, we may deny your request to inspect or copy your records such as if we believe it may endanger you or someone else. If you are denied access to your medical information, you may request that the denial be reviewed by another licensed health care professional. We will comply with the outcome of the review.

Right to Request an Amendment: If you feel that the medical information we have about you is incorrect or incomplete, you may ask us to amend the information for as long as the information is kept by or for Bon Secours in your medical and billing records. To request an amendment, your request must be submitted in writing and provide the reason for the request. If we agree to your request, we will amend your record(s) and notify you of such. In certain circumstances, we cannot remove what was in the record(s), but we may add supplemental information to clarify. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

Right to an Accounting of Disclosures: You have a right to receive a list of certain of the disclosures we have made of your medical information in the six years prior to your request. To request an accounting of disclosures you must submit your request in writing to the Privacy Officer. You must state the time period for which you want to receive the accounting, which may not be longer than six years and which may not date back more than six years from the date of your request. You must indicate whether you wish to receive the list electronically or on paper. The first accounting you receive in a 12 month period will be free. We may charge you for responding to additional requests in that same period. We will inform you of the costs involved before any costs are incurred. You may choose to withdraw or modify your request at that time.

Right to Request Restrictions: You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we not disclose information to a family member about a surgery you had. If we agree to your request, we will comply with your request unless the information is needed to provide you with emergency treatment or we are required by law to disclose it. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations of the health plan, and the information pertains solely to a health

care item or service for which we have been paid out of pocket in full. For example, when a patient wants cosmetic surgery and pays for it out of pocket, upon request we will not send any claim to the insurance carrier.

To request a restriction you must make your request in writing and tell us (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply, i.e. disclosures to your spouse. We are allowed to end the restriction if we tell you. If we end the restriction, it will only affect the health information that was created or received after we notify you.

Right to Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you may ask that we contact you only at home or by mail. If you want us to communicate with you in a certain way, you will need to give us specific details about how you want to be contacted including a valid alternative address. We will not ask you the reason for the request, and we will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have.

Right to a Paper Copy of This Notice: You have the right to a paper copy of this notice at any time, even if you have previously agreed to receive this notice electronically. Copies of this notice are available throughout Bon Secours Hampton Roads or by contacting the Bon Secours Hampton Roads Privacy Officer.

Change to This Notice

We reserve the right to change this notice and Bon Secours' privacy practices. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice on the Bon Secours Hampton Roads website at bonsecours.com/Hampton-roads.

Questions or Complaints

If you have questions or believe that your privacy rights have been violated, you may file a complaint with Bon Secours Hampton Roads or with the Secretary of the Department of Health and Human Services. To file a complaint with Bon Secours Hampton Roads, contact the Privacy Officer. ***You will not be penalized for filing a complaint.***

Addresses

The address for our Privacy Officer is:

5818 Harbour View Blvd, Suite A1
Suffolk, VA 23435

The address for our Corporate Privacy Officer is:

1505 Marriottsville Road
Marriottsville, MD 21104

The address for the Department of Health and Human Services is:

The U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

This Notice is effective September 23, 2013 and replaces all earlier versions.