PATIENT REGISTRATION FORM

PATIENT INFORMATION: THIS SECTION REFERS TO THE PATIENT ONLY

Last Name: _____ First Name: _____ MI: _____ Social Security #: _____

Address: _____ City: _____ State: _____ Zip: _____

Email: _____ Occupation: _____

Date of Birth: _____ **Sex:** M F **Marital Status:** Married Single Divorced Widowed **Preferred Language:** _____

Race: ☐ American Indian or Alaska native ☐ Asian ☐ Black or African American

☐ Native Hawaiian or other Pacific Islander ☐ White ☐ Unknown/Declined to answer

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown/Declined to answer

Home phone: (_____)_____ cell phone: (_____)_____ work phone: (_____)_____

Best daytime number to reach you: ☐ home ☐ work ☐ cell Is it ok to leave a message at any of the numbers? ☐ Yes ☐ No

If no, please designate which ones, if any: _____

Primary Care Physician's Name (if applicable): _____ How did you hear about us? _____

Spouse's Name: _____ Date of Birth: _____ Spouse's SS#: _____

RESPONSIBLE PARTY: THIS SECTION REFERS TO THE PERSON/PARTY WHO SHOULD RECEIVE THE BILL

Relationship to Patient: ☐ Self (skip to next section) ☐ Parent ☐ Spouse ☐ Other (skip to next section) _____

Last Name: _____ First Name: _____ MI: _____

Social Security Number: _____ Birth date (mm/dd/yyyy): _____ Sex: ☐ Male ☐ Female

Address: _____ City: _____ State: _____ Zip: _____

Home phone: (_____)_____ Cell phone: (_____)_____ Work phone: (_____)_____

INSURANCE INFORMATION

Primary Insurance Coverage: _____ Copay: $_____

Policy effective date: _____ Deductible: $_____ Met? ☐ Yes ☐ No If no, amount met: $ _____

Address: _____ City: _____ State: _____ Zip: _____

Policy Number: _____ Group Number: _____ Subscriber: _____

Subscriber's DOB: _____ Subscriber's SS #: _____

Secondary Insurance Coverage: _____

Address: _____ City: _____ State: _____ Zip: _____

Policy Number: _____ Group Number: _____ Subscriber: _____

Subscriber's DOB: _____ Subscriber's SS #: _____

Communication with Family Members and Friends Involved In Patient Care

This form documents my request to allow family members and/or friends to be involved in relevant ***verbal discussions*** regarding my health care. By signing this form, I permit Baptist Medical Group ("BMG") staff to discuss information about me with the people listed below. This information may include diagnoses, test results, treatments, and payment information, but shall be limited to only the information that, in the professional judgment of your provider, needs to be shared.

I understand that signing this form is voluntary and that I am not required to sign this form in order to receive health care.

I understand that information may be released to family members or others without this form, if allowed by federal and state law.

I understand that listing a person on this form does not give them the right to receive or copy my written medical records. It does not allow them to consent for health care services on my behalf.

I understand that my health care provider will discuss only the information that the person involved needs to know about my care or treatment.

I can update this form at any time by completing a new form and giving it to BMG staff.

I understand that BMG staff will verify the identity of the people below (if not known to the staff) prior to discussing this information.

I understand that this is not a Health Insurance Portability and Accountability Act (HIPAA) authorization form that would allow the people below to have access to my written Protected Health Information

Name	Phone Number	Relationship
Name	Phone Number	Relationship
Name	Phone Number	Relationship
Name	Phone Number	Relationship

Signature	_____	
Print Name	_____	
Date	____ / ____ / _____	Time ____ : _____

Relationship to Patient

- ☐ Self
- ☐ Legal Representative or Guardian (proof of power of attorney or legal guardianship required)

Patient Name: _____ DOB: _____

Today's Chief Complaint: _____ Referring Doctor: _____

PATIENT MEDICAL HISTORY

Please **circle** any medical problem(s) you have had in the past or may currently have.

Medical Problem:	Date:	Medical Problem:	Date:	Medical Problem:	Date:
Breast Cancer		Low White Blood Cells		Heart Disease	
Colon Cancer		High White Blood Cells		Hypertension	
Head and Neck Cancer		Other Blood Disorder		Migraines	
Lung Cancer		Allergies		Obesity	
Ovarian Cancer		Asthma		Renal disease	
Prostate Cancer		Autoimmune disease		Seizure disorder	
Other Cancer:		Cardiovascular disease		Sickle cell	
Anemia		Coronary artery disease		Stroke	
Low Platelets		Depression		Thyroid Disorder	
High Platelets		Diabetes		Other:	

PATIENT SOCIAL HISTORY

Please **circle** below and provide frequency of use:

Tobacco Usage (current or former): Yes No	What Type of Tobacco: Cigarettes Cigars Smokeless Tobacco	Start Date: Stop Date:
Packs/Amount per day:		
Alcohol Consumption: Yes No	Frequency: Daily Weekly Monthly	Amount per Frequency:

PATIENT SURGICAL HISTORY

Please list any past surgeries you may have and provide the date beside it.

_____

_____

_____

MEDICATION HISTORY

Allergy	Severity (Minor, Moderate, Major)	Reaction

Please list **current medication(s)** or provide a list: _____

_____

_____

_____

_____

FAMILY MEDICAL HISTORY

Please **circle** any relevant family medical history. If circled, please write in onset age and relationship to patient.

	Onset Age & Relationship		Onset Age & Relationship		Onset Age & Relationship
Breast Cancer		Low White Blood Cells		Heart Disease	
Colon Cancer		High White Blood Cells		Hypertension	
Head and Neck Cancer		Other Blood Disorder		Migraines	
Lung Cancer		Allergies		Obesity	
Ovarian Cancer		Asthma		Renal disease	
Prostate Cancer		Autoimmune disease		Seizure disorder	
Other Cancer:		Cardiovascular disease		Sickle cell	
Anemia		Coronary artery disease		Stroke	
Low Platelets		Depression		Thyroid Disorder	
High Platelets		Diabetes		Other:	

Patient Signature: _____ **Date:** _____

Patient Name: _____

DOB: _____

General

- ☐ Anorexia
- ☐ Chills
- ☐ Fever
- ☐ Malaise/Fatigue
- ☐ Weight Loss
- ☐ Feeling Well
- ☐ Compliance with Diet
- ☐ Dietary Changes
- ☐ Medication Changes

Skin

- ☐ Jaundice/Yellow Skin
- ☐ Lesions
- ☐ Pruritus/Itching
- ☐ Rash
- ☐ Varicose Veins
- ☐ Normal
- ☐ Skin Color Change
- ☐ Tattoo/Piercing

Breast

- ☐ Breast Lump
- ☐ Nipple Discharge
- ☐ Tenderness
- ☐ Swollen Glands
- ☐ Swelling
- ☐ Nipple Pain
- ☐ Recent Breast Changes

Eye

- ☐ Itching
- ☐ Lacrimation/Watery Eyes
- ☐ Pain
- ☐ Light Induced Pain
- ☐ Vision Changes
- ☐ Discharge
- ☐ Visual Disturbances
- ☐ Dryness

Ear

- ☐ Discharge
- ☐ Hearing Disturbance
- ☐ Hearing Loss
- ☐ Pain
- ☐ Tinnitus/Ringing in Ears
- ☐ Pulling Ear

Nose

- ☐ Congestion
- ☐ Discharge
- ☐ Nose Bleeds
- ☐ Obstruction
- ☐ Sneezing
- ☐ Decreased Sense of Smell
- ☐ Running Nose

Mouth/Throat

- ☐ Difficulty swallowing
- ☐ Hoarseness
- ☐ Lesions
- ☐ Rash
- ☐ Throat Pain
- ☐ Coated Tongue/ Mucous Membranes
- ☐ Dental Problems
- ☐ Sore Throat
- ☐ Voice Changes
- ☐ Dryness

Respiratory

- ☐ Cough
- ☐ Difficulty Breathing
- ☐ Coughing Up Blood
- ☐ Pleuritic Chest Pain
- ☐ Wheezing
- ☐ Difficulty Breathing on Exertion
- ☐ Shortness of Breath at Rest
- ☐ Sputum Production

Cardiovascular

- ☐ Chest Pain
- ☐ Claudication/Leg Pain
- ☐ Lower-extremity Swelling
- ☐ Shortness of breath
- ☐ Palpitation
- ☐ Fainting
- ☐ Feels Faint at Times
- ☐ Irregular Heart Beat

Patient Name: _____

DOB: _____

Gastrointestinal

- ☐ Abdominal Pain
- ☐ Constipation
- ☐ Diarrhea
- ☐ Nausea
- ☐ Vomiting
- ☐ Black Tarry Stool
- ☐ Change in Bowel Habits
- ☐ Difficulty Swallowing
- ☐ Heartburn
- ☐ Indigestion
- ☐ Mucous in Stool
- ☐ Stool Incontinence

Gastrorectal

- ☐ Change in Bowel Habits
- ☐ Blood in Stool
- ☐ Black or Tarry Stool
- ☐ Rectal Pain
- ☐ Stool Incontinence

Genitounirary

- ☐ Painful/difficult Urination
- ☐ Hematuria/Blood in Urine
- ☐ Sexual Dysfunction
- ☐ Urinary Frequency
- ☐ Urinary Hesitance
- ☐ Urinary Incontinence
- ☐ Change in Bladder Habits

Gynecological

- ☐ Change in Menses
- ☐ Pain During intercourse
- ☐ Vaginal Discharge
- ☐ Vaginal Pruritus
- ☐ Vulvar Swelling

Neurological

- ☐ Confusion/Memory Loss
- ☐ Dizziness
- ☐ Headache
- ☐ Numbness
- ☐ Weakness
- ☐ Change in Consciousness
- ☐ Unsteadiness
- ☐ Change in Speech
- ☐ Difficulty Speaking
- ☐ Difficulty with Ambulation
- ☐ Tingling
- ☐ Loss of Balance
- ☐ Seizures
- ☐ Unusual Sensation

Psychiatric

- ☐ Anxiety
- ☐ Depression
- ☐ Hallucinations
- ☐ Insomnia
- ☐ Mood Problems
- ☐ Fearful
- ☐ Suicidal Thoughts
- ☐ Delusions

Musculoskeletal

- ☐ Pain in Joints
- ☐ Back Pain
- ☐ Joint Swelling
- ☐ Pain
- ☐ Stiffness
- ☐ Joint Redness
- ☐ Appetite Changes
- ☐ Muscle Pain/Myalgia
- ☐ Muscle Weakness

Heme/Lymph

- ☐ Bleed/Bruise Easily
- ☐ Enlarged/Tender Lymph Nodes
- ☐ Night Sweats
- ☐ Abnormal Bleeding
- ☐ Anemia

Endocrine

- ☐ Change in Weight
- ☐ Cold/Heat Tolerance
- ☐ Hot Flashes
- ☐ Increased Thirst
- ☐ Excessive Urination

Patient Name: _____

DOB: _____

(For Staff Use Only)
Prescriptions needing refill

Drug Name	Refilled	Discontinued	Added
_____	☐	☐	☐
_____	☐	☐	☐
_____	☐	☐	☐
_____	☐	☐	☐

Patient Responsibility Agreement

Welcome to Baptist Medical Group (BMG), part of Baptist Health Care. We understand you have many choices when it comes to health care and we are glad you chose our medical group. We look forward to providing you with quality health care that is accessible, comprehensive, team-based, coordinated, and focused on your health and safety. Please review the following patient responsibilities, sign and return.

OBLIGATION TO PAY MY BMG BILL: I understand that all charges for services rendered by BMG are due and payable at the time of service. If I have health care insurance, I agree to pay for any deductibles, co-payments and the patient responsibility portion of the fee at the time of service. I acknowledge that I am financially responsible for my BMG bills (or, if signed by a guarantor, the guarantor is responsible) which are not paid for by my health insurance plan, and I agree to pay the bill promptly.

MEDICAL INSURANCE: I acknowledge that billing my health plan is a service provided by BMG. I will inform BMG of any changes in address or phone number for myself and/or responsible party, present my photo ID and all insurance identification cards upon request. I understand I may be responsible for the entire BMG bill if my health plan refuses to pay after reasonable attempts to collect from the health plan.

APPOINTMENTS: I agree to bring a list of all medications I am currently taking to each appointment. I agree to check in on time for my appointment. I understand that if I am late for my appointment, I will be re-scheduled for the next available appointment time and understand there may not be an appointment available the same day. I agree to notify the office at least 24 hours in advance of my appointment if I find I must cancel my appointment. I understand that failure to notify the office 24 hours in advance will result in a $25.00 missed appointment fee, which cannot be billed to insurance. I understand my patient/physician relationship may be terminated if I miss more than three appointments.

AUTHORIZATIONS AND REFERRALS: I understand that I am responsible for notifying the practice if my health plan requires pre-authorizations for tests or for referrals to specialists. I understand the BMG office staff may assist me with scheduling referrals and/or diagnostic testing but failure to obtain necessary authorizations before the scheduled appointment may result in the visit/test needing to be rescheduled and/or charges being billed directly to me.

FINANCIAL ASSISTANCE: I understand there are financial assistance programs available for patients who are unable to pay for their care based upon a determination of financial need in accordance with the BMG financial assistance policy. I understand it is my responsibility to contact a Patient Account Specialist at BMG's business office at (850) 475-3500 to request financial assistance. I agree to provide my personal financial information and/or submit to a credit check to determine if I qualify for financial assistance. If I do not qualify for financial assistance and do not have health insurance, I understand and agree that I will pay in full for all services at the time of service. If I do not have insurance, a 30% discount will be applied when full payment is made at time of service.

RETURN CHECK POLICY: I understand I will be responsible for all service charges and collection fees associated with collecting any bad check I write to BMG and will pay these fees upon notice.

NON-PAYMENT ON ACCOUNT: I understand that if my BMG account has a balance due older than 90 days old, it may be placed with an outside agency for collection and all relevant personal and account information necessary to collect payment for services will be revealed. I understand that I am responsible for all fees for collecting these past due balances including, but not limited to, collection fees, court costs and attorney fees. I understand BMG may, upon written notice, terminate the patient / physician relationship due to non-payment on account.

BUSINESS HOURS: I understand unusual circumstances will sometimes require the office hours to be changed without notice. I understand the pre-recorded telephone message will let me know when to call back for routine requests and what to do in case of an urgent medical need (one that does not require emergency treatment). I understand that I should call 911 in the event of a medical emergency or proceed to the closest emergency room for treatment.

PRESCRIPTIONS AND/OR REFILLS: I understand that requests for new medication and/or refills should be made during my visit with my provider If I need a prescription refill between visits, I agree to contact my pharmacy and allow 48 to 72 business hours to process. I understand refill requests will only be processed during office hours. I understand that narcotic prescriptions are highly regulated and may require a signed narcotics agreement between me and my provider. I agree to carefully read all stipulations in the narcotics agreement and abide by these. I understand that my physician will refill narcotics only when appropriate and only during the office visit; no refills after hours and no refills via phone request.

PATIENT FORMS COMPLETION: I understand that an office visit may be necessary if I request the provider complete certain forms for me. There is also a nominal fee, payable in advance, for the completion of these forms. I understand these requests may take up to 14 days for processing.

MEDICAL RECORDS: I understand that in compliance with applicable state and federal law, in some cases, appropriate authorization forms must be completed and signed by the patient before records are released. Florida law allows office practices to charge a fee for providing these medical records to cover labor, equipment and supplies, which will be collected prior to the release of medical records.

PATIENT PORTAL: I understand many of the BMG practices have a patient portal to offer me a secure online website for convenient 24-hour access to my personal health information. This is an optional program using a secure username and password. Recent doctor visit notes, medications, contact information and health records can be viewed and printed. The office staff can provide more information regarding the Patient Portal.

WIRELESS COMMUNICATION: By providing a wireless or mobile telephone number, I give permission to BMG to use this number for contact. Contact includes receiving calls and messages, including pre-recorded messages and calls via an automatic telephone dialer from BMG and their authorized agents.

BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE READ, UNDERSTAND AND AGREE TO ABIDE BY THE ABOVE PATIENT RESPONSIBILITIES.

Patient/Guardian Signature	**Date**
Print Patient/Guardian's Name from above	**Guardian's relationship to patient**

Thank you again for choosing Baptist Medical Group

BAPTIST MEDICAL GROUP

CONTROLLED SUBSTANCE AGREEMENT

The State of Florida has laws governing the prescription of controlled substances. These drugs include all opioids (such as codeine, hydrocodone and oxycodone), sleeping aids, benzodiazepines (such as Valium, Xanax and Ativan) and ADHD medications (such as Concerta, Metadate CD, Ritalin and Vyvanse). To comply with Florida law, I acknowledge and agree to the following:

- Prescriptions for most controlled substance medications can only be written for a 30 day supply.
- I will not use any illegal controlled substances, such as marijuana and cocaine.
- I will not share, sell or trade my medication with anyone.
- I will safeguard my medicine from loss or theft. Lost or stolen prescriptions, written or filled, will not be replaced.
- I will use my medicine at a rate no greater than the prescribed rate and that the use of my medicine at a greater rate will result in my being without medication for a period of time. If requested by my doctor, I will bring all unused pain medicine to every office visit.
- I will request refills of my controlled substance only during an office visit or during regular office hours. No refills will be available during evenings or on weekends.
- I must be seen by my doctor no less than every 3 months to continue to get refills.
- I will submit to a blood or urine test within 24 hours of when requested by my doctor to determine my compliance with these policies and my program of pain control medicine.
- I will communicate fully and truthfully with my doctor about the character and intensity of my pain, the effect of the pain on my daily life and how well the medicine is helping to relieve the pain.
- I will obtain all controlled medicines **only** from the physician listed below. If I see another doctor who gives me a controlled substance medicine (for example, a dentist, a doctor from the Emergency Room or another hospital, etc.) I must bring this medicine to this office in the original bottle, even if there are no pills left**.**
- I acknowledge controlled substance medications have inherent risks associated with their use. These risks include but are not limited to the following: Physical dependence, Psychological dependence, potential for overdose, and potential for withdrawal syndrome.

I agree to comply with the terms of this agreement. I understand that my physician has the right to discontinue prescribing me controlled substance medications and discharge me from care if I do not comply with the terms of this agreement. I hold Baptist Medical Group and its staff harmless from any liability in the event I am dismissed from the practice for failure to abide by this agreement.

I agree to use _____ (pharmacy), located at _____ (address) for filling prescriptions for all of my controlled substance medications. If my pharmacy location changes, I will promptly notify the office.

Patient Name: _____ DOB: _____ Date: _____

Patient Signature: _____

Physician Name: _____

Physician Signature: _____

ADVANCE DIRECTIVES:

Speak for Yourself

A Guide to Understanding Advance Directives and Living Wills

This document was prepared to provide information in general terms on health care advance directives and to explain Baptist Health Care's policies and procedures governing advance directives. This is general information and not specific advice. You may want to consult your personal attorney, spiritual advisor, family and friends before completing any advance directive. Signing an advance directive is not a condition of admission or continued stay in this facility.

A Patient's Right to Decide

Every competent adult has the right to make decisions concerning his or her own health, including the right to choose or refuse medical treatment.

When a person becomes unable to make decisions due to a physical or mental change, such as being in a coma or developing dementia (like Alzheimer's disease), they are considered incapacitated. To make sure that an incapacitated person's decisions about health care will still be respected, the Florida legislature enacted legislation pertinent to health care advance directive. The law requires the right of a competent adult to make an advance directive instructing his or her physician to provide, withhold, or withdraw life-prolonging procedures; to designate another individual to make treatment decisions if the person becomes unable to make his or her decisions; and/or to indicate the desire to make an anatomical donation after death.

By law, hospitals are required to provide their patients with written information, such as this pamphlet, concerning health care advance directives.

Questions About Health Care Advance Directives

What is an advance directive?

It is a written or oral statement about how you want medical decisions made should you not be able to make them yourself and/or it can express your wish to make and anatomical donations after death. Some people make advance directives when they are diagnosed with a life-threatening illness. Others put their wishes into writing when they are healthy, often as part of their estate planning.

Three types of advance directives are:

- A Living Will
- A Health Care Surrogate Designation
- An Anatomical Donation

You might want to choose one, two, or all three of these forms.

What is a living will?

It is a written or oral statement of the kind of medical care you want or do not want if you become unable to make your own decisions. It is called a living will because it takes effect while you are still living. You may wish to speak to your health care provider or attorney to be certain you have completed the living will in a way that your wishes will be understood.

What is a health care surrogate designation?

It is a document naming another person as your representative to make medical decisions for you if you are unable to make them yourself. Your can include instructions about any treatment you want or do not want, similar to a living will. You can also designate an alternate surrogate.

What is an anatomical donation?

It is a document that indicates your wish to donate, at death, all or part of your body. This can be an organ and tissue donation to persons in need, or a donation of your body for training of health care workers. You can indicate your choice to be an organ donor by designating it on your driver's license or state identification card (at your nearest driver's license office), signing a uniform donor form, or expressing your wish in a living will.

Am I required to have an advance directive under Florida law?

No, there is no legal requirement to complete an advance directive. However, if you have not made an advance directive, decisions about your health care or an anatomical donation may be made for you by a court-appointed guardian, your spouse, your adult child, your parent, your adult sibling, an adult relative, or a close friend. The person making decisions for you may or may not be aware of your wishes. When you make an advance directive, and discuss it with the significant people in your life, it will better assure that your wishes will be carried out the way you want.

Must an attorney prepare the advance directive?

No, the procedures are simple and do not require an attorney, though you may want to consult one.

However, an advance directive, whether it is a written document or an oral statement, needs to be witnessed by two individuals. At least one of the witnesses cannot be a spouse or a blood relative.

Can I change my mind after I write an advance directive?

Yes, you may change or cancel an advance directive at any time. Any changes should be written, signed, and dated. However, you can also change an advance directive by oral statement; physical destruction of the signed advance directive; or by writing a new advance directive. If your driver's license or state ID care indicates you are an organ donor, but you no longer wish this designation, contact the nearest driver's license office to cancel the donor designation.

What if I filled out an advance directive in another state and need treatment in Florida?

An advance directive that is properly completed in another state as described in that state's law can be honored in Florida.

What should I do with my advance directive if I choose to have one?

- If you designate a health care surrogate be sure to ask them to agree to take this responsibility, discuss how you would like matters handles, and give them a copy of the document.
- Make sure your health care provider, attorney, spiritual advisor, and the significant persons in your life know that you have an advance directive and where it is located. You may also give them a copy.
- Keep a copy in a place where it can be easily located, such as a file of important papers. Some people keep original papers in a bank safety deposit box. If you do, you may want to keep copies at your house or information concerning the location of your safety deposit box.
- Keep a card or note in your purse or wallet that state you have an advance directive and where it is located.
- If you change your advance directive, make sure your health care provider, attorney and the significant persons in your life have the latest copy.

If you have questions about your advance directive you may want to discuss these with your health care provider, attorney, spiritual adviser, or the significant persons in your life.

What are some other options?

Durable Power of Attorney

As an alternative to a health care surrogate, or in addition to, you might want to designate a durable power of attorney. Through a written document you can name another person to act on your behalf. It is similar to a health care surrogate, but the person can be designated to perform a variety of activities (financial, legal, medical, etc.). You can consult an attorney for further information.

Do Not Resuscitate Order

If you are terminally ill (or if you have a loved one who is in a persistent vegetative state) you may want to consider having a pre-hospital Do Not Resuscitate Order (DNRO). A DNRO identifies people who do not wish to be resuscitated from respiratory or cardiac arrest.

Advance Directives in the Outpatient Setting

Unlike in an inpatient acute care hospital setting, outpatient clinics and procedural areas do not routinely perform high risk procedures. Therefore, unless your doctor specifically writes a Do Not Resuscitate Order, it is Baptist's policy that resuscitative or other stabilizing measures will be performed on you if any clinical deterioration occurs during your outpatient treatment, regardless of the contents of your advance directive or DNRO.

Resources for more information and/or assistance

- Baptist Hospital's Care Management Department – 850.469.2096
- Gulf Breeze Hospital's Case Management Department – 850.934.2044
- Jay Hospital's Social Services Department – 850.675.8061
- http://www.floridahealthfinder.gov
- projectgrace.org
- Your personal attorney

Living Will

Declaration made this _____day of _____,
20_____, I_____,

willfully and voluntarily make known my desire that my dying not be artificially prolonged under the circumstances set forth below, and I do hereby declare: If at any time I should have a terminal condition and if my attending or treating physician and another consulting physician have determined that there is not medical probability of my recovery from such condition, I direct that life-prolonging procedures be withheld or withdrawn when the application of such procedures would serve only to prolong artificially the process of dying, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care and alleviate pain.

It is my intention that this declaration be honored by my family and my physician as the final expression of my legal right to refuse medical or surgical treatment and to accept the consequences of such refusal.

In the event that I have been determined to be unable to provide express and informed consent regarding the withholding, withdrawal or continuation of life-prolonging procedures, I wish to designate as my surrogate to carry out the provisions of this declaration:

Name_____
Address _____
City _____State_____Zip Code _____
Phone _____

I understand the full import of this declaration, and I am emotionally and mentally competent to make this decision.
Additional Instructions (optional)_____
_____
_____

Signature _____
Witness Signature_____
Address_____
_____
Phone _____

Witness Signature_____
Address _____
_____
Phone _____

Designation of a Health Care Surrogate

Name_____
Last First Middle Initial

In the event that I have been determined to be incapacitated to provide informed consent for medical treatment and surgical and diagnostic procedures, I wish to designate as my surrogate for health care decisions:

Name_____
Address_____
City_____ State____Zip Code_____
Phone_____

If my surrogate is unwilling or unable to perform his/her duties, I wish to designate as my alternate surrogate:

Name _____
Address _____
City_____ State____Zip Code _____
Phone _____

I fully understand that this designation will permit my designee to make health care decisions and to provide, withhold or withdraw consent on my behalf; to apply for public benefits to defray the cost of health care; and to authorize my admission to or transfer from a health care facility.

Additional Instructions (optional) _____
_____
_____

I further affirm that this designation is not being made as a condition of treatment or of admission to a health care facility. I will notify and send a copy of this document to the following persons other than my surrogate, so they may know who my surrogate is.

Name _____
Name _____
Name _____
Name _____

_____
Signature

_____
Date

Witnesses _____
_____
_____
_____

- This request must be made in writing and tell us how you would like to be contacted.
- We will agree to reasonable requests.

- **Right To Amend:**
  - You can ask us to change your medical information. For example, you can ask us to correct errors such as your date of birth.
  - This request must be made in writing to the appropriate office listed at the end of this Notice with an explanation as to why the amendment is being requested.
  - The law does not require us to agree to your request. If we deny your request, we will notify you in writing, including the reasons for the denial.
  - If we deny your request to change your medical information you can appeal our decision. Your appeal must be made in writing.
- **Right To An Accounting:**
  - You can ask us to give you a list of disclosures we have made of your medical information within the six years prior to your request.
  - This list will not include every disclosure made including those disclosures made for treatment, payment and healthcare operations purposes.
  - This also does not include information shared at your request.
  - This request must be made in writing to the appropriate office listed at the end of this Notice.
  - If you request more than one accounting in a twelve-month period, we may charge you a fee.
- **Right To Be Notified In The Event Of A Breach:**
  - We will notify you if your medical information has been used or disclosed in a way that is not consistent with law and results in your medical information being compromised.
- **Right To A Paper Copy Of This Notice:** If asked, we will give you a paper copy of this Notice.

Other Use Of Your Medical Information Without Your Authorization:

- We will not share your medical information except in the ways indicated in this Notice unless you give us your written authorization to do so.
- Most uses and disclosures of psychotherapy notes and uses and disclosures for marketing purposes fall within this category and require your authorization.
- With certain limited exceptions, we are not allowed to sell or receive anything of value in exchange for your medical information without your written authorization.
- If you provide us authorization to use or disclose medical information about you, you may revoke (withdraw) that authorization, in writing, at any time. However, uses and disclosures made before your withdrawal are not affected by your action and we cannot take back any disclosures we may have already made with your authorization.

Questions or Complaints

We ask that you please give us the opportunity to resolve any issues you have concerning your privacy. If you feel that we have violated your privacy, you may file a written complaint with the Baptist Health Care Privacy Officer at the address below. If you prefer, we will be happy to assist you in completing a written complaint. **There will be no retaliation against you for filing a complaint.** For further information or assistance, you may contact us at:

Privacy Officer
Baptist Health Care Corporation
Governance, Risk & Compliance (GRC)
1717 North E Street, Suite 409; Pensacola, FL 32501
850.434.4472

You also have the right to file a complaint with the Secretary of the U.S. Department of Health and Human Services but we ask that you first allow us the opportunity to correct any issues you may have concerning your privacy.

Effective Date: June 1, 2015

NOTICE OF PRIVACY PRACTICES

BAPTIST HEALTH CARE

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.

Our Pledge Regarding Your Medical Information

Your privacy is important to us. The law requires us to maintain the privacy of your medical information and to tell you our duties and practices regarding your medical information. The law requires us to follow the terms of our current Notice. We reserve the right to make changes to this Notice, which may include new privacy provisions about the medical information that we already have about you as well as any information we receive in the future. If we make any changes, we will give you a copy of the new Notice the next time you visit us. The latest version of this Notice can always be found on our website at www.ebaptisthealthcare.org. In addition, you may request a copy of the Notice currently in effect.

We are providing this Notice so that you understand:

- Who will follow this Notice
- How we may use and share your medical information
- Your rights concerning your medical information
- How to file a complaint about your privacy

Who Will Follow This Notice:

This notice applies to all Baptist Health Care providers providing health care to the public at all of its delivery sites including, but not limted to:

- Andrews Institute Rehabilitation
- Baptist Hospital
- Baptist Medical Group
- Baptist Medical Park – Nine Mile
- Baptist Medical Park – Navarre
- Baptist Medical Park Surgery Center
- Baptist Occupational Health
- Baptist Physician Group
- Baptist Physician Associates
- Baptist Urgent Care
- Cardiology Consultants
- Gulf Breeze Hospital
- Jay Hospital
- The Towers Pharmacy
- All health care professionals, employees, medical staff, trainees, students and volunteers of Baptist Health Care

This Notice does not include Lakeview Center, Inc., or those physicians who are not employed by Baptist Health Care. Those providers should provide you a separate Notice that explains how they will collect, use and disclose your medical information.

How We May Use and Share Your Medical Information:

- **Treatment Purposes:** We may share your information with those who are caring for you. For example, if you come in with a broken arm, we will give your x-rays to your doctor. If you need medication, the doctor may share your information with your pharmacist.
- **Payment Purposes:** We may share your medical information with the person or company paying for your care. For example, if you come to us with a broken arm, we will tell your insurance company why you came in and what we did for you.
- **Health Care Operations:** We may use your medical information to improve the way we provide care to you and others. For example, we may share your medical information to teach others.
- **Health Information Exchange:** We may share your medical information with other health care providers for treatment, payment and health care operations as permitted by law through an approved Health Information Exchange (HIE). Exchange of medical information

can provide faster access, better coordination of care and assist providers and public health officials in making more informed treatment decisions.

- **Appointment Reminders:** We may contact you to remind you about your appointment. Please tell us if you do not want your information used in this way.
- **Sign-in Sheets:** We may use sign-in sheets in our offices and call your name when the doctor is ready to see you.
- **Treatment Choices and Health Promotions:** We may send you information about different ways to treat you and about other health benefits or services that you may want to know about.
- **Fundraising:** We may contact you to provide information about BHC sponsored activities, including fundraising programs and events to support research, education or patient care at BHC. For this purpose, we may use your contact information, such as your name, address and phone number, the dates on which and the department from which you received services, your treating physician's name, your treatment outcome, and your health insurance status. The communication you receive will have instructions on how you may ask us not to contact you again for such purposes, also known as an "opt-out".
- **Research:** We may share your information for research. The law requires us to take extra steps to protect your privacy and tell why we will be using your information.
- **Hospital Directory:** We may use your information in our directory. Our directory has your name, religion, room number and how you are doing. If someone asks for you by name we will tell them your room number and how you are doing. We may allow members of the clergy to see our directory even if they do not ask for you by name. Please tell us if you do not want to be listed in our directory.
- **People Involved In Your Care:** We may share your medical information with a family member or a friend who is involved in your care. We may also share your information with a person or company who is helping pay your bill. Please tell us if you do not want your information shared in this way.
- **Disaster Relief:** If there is a disaster such as a hurricane, plane crash or tornado we may use your medical information to notify your family. We may also release information to an agency such as the Red Cross. Please tell us if you do not want your information shared in this way.
- **Satisfaction Surveys:** We may use your information to contact you requesting feedback on the services provided to you by BHC. Your answers will help us provide better care to our patients and the community we serve.
- **Special Programs:** If you sign-up for one of our programs such as Golden Care, we may share your health information with our volunteers and others so they can check on you while you are in our care.
- **Security Cameras:** To increase the level of security in our facilities, we sometimes use security cameras and recorders in public areas such as hallways and parking lots. We do not use these devices in any private areas such as patient or exam rooms unless doing so is part of the treatment we provide

How We May Share Your Medical Information Without Your Permission:

- **As Required By Law:** An example is the mandatory reporting of positive cancer tests to State agencies.
- **To stop a serious threat to someone's health or safety:** We may only share this information with someone who can stop the threat.
- **For Public Health:** We may share your medical information with a public health agency such as the Centers for Disease Control.
- **Law Enforcement:** In some situations we may share your medical information with law enforcement. If we believe you are a victim of abuse or some other crime we may tell the police. We may also tell the police if you commit a crime at our facility.
- **State and Federal Review:** We may share your medical information when being reviewed. For example we may share your information with Medicare or Medicaid when they are reviewing the way we provide care.
- **Legal Proceedings:** We may share your medical information when responding to proper requests in legal proceedings.
- **Children:** In some cases we may not share your child's medical information with you. For example, there are times when your child can seek care without your permission.
- **Organ Donation:** If you are an organ donor we may share your medical information when appropriate.
- **In Case of Death:** We may share your medical information with a medical examiner or funeral director.
- **Military and Veterans:** If you are in the military or a veteran, we may share your medical information when required by law.
- **National Security:** We may share your medical information when required by law for national security purposes.
- **Protection of the President and others:** We may share your medical information when required by law for protection services of the President and other important leaders.
- **Department of State:** We may share your medical information when required for security clearances and physicals of State Department personnel and their dependents.
- **Inmates:** If you are a prisoner or in police custody, we may share your medical information when required by law.
- **Work Injuries:** If you are getting care because you were hurt at work we may share your medical information with your employer and others as required by Workers' Compensation laws.

Health Information With Additional Protections

Certain types of medical information may have additional protection under federal or state law, for example, if you are receiving behavioral health services from us, your name will not be listed in our Hospital Directory and will not be shared for fundraising purposes. Also, federally assisted alcohol and drug abuse programs are subject to special restrictions on the use and disclosure of related treatment information

Your Rights Concerning Your Medical Information:

- Right To Request Restrictions:
  - You can ask us not to share your medical information for treatment, payment and health care operations. Usually, we will not agree to this request because it would make it difficult for us to care for you.
  - You can ask us not to share your medical information with family or friends who are involved in your care.
  - If you want to make any of these requests you must do so in writing. The law does not require us to agree to your request.
  - If you need emergency treatment we may share your medical information even if you have asked us not to.
  - As of September 23, 2013, if you request that we not disclose certain medical information to your health insurer and that medical information relates to a health care product or service for which we have received payment from you in full, then we must agree to that request.
- Right To See And Get A Copy:
  - You have the right to see and get a copy of your medical information for as long as we have it.
  - We may charge a fee for giving you a copy.
  - Sometimes the law does not allow us to let you see your medical information. If this happens, you can appeal our decision. Your appeal must be made in writing.
- Right To Request Confidential Communications:
  - You can ask us to contact you in certain ways. For example, you can ask that we not send your bills or appointment reminders to your home address or call you at your work number.