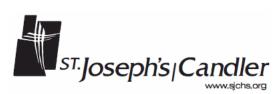


St. Joseph's/Candler Physician Network would like to welcome you to our practice.

We appreciate the opportunity to take care of your healthcare needs, and we look forward to serving you. Your health is our primary concern. Our philosophy is to provide comprehensive care while treating every patient with dignity and respect. We offer a wide variety of services and preventive programs to address your physical wellbeing.

In order to expedite the new patient registration process, we ask that you complete the enclosed Patient Registration Forms and bring with you to your appointment. Please do not mail forms to the practice. Completing this information ahead of time allows us to see you in a timely manner upon your arrival at our office and ensures we have the information necessary to fully address your healthcare needs.

What to bring:		
☐ Completed and signed Patient Reg	istration Forms;	
☐ A copy of your current insurance ca	ard(s);	
☐ Photo identification, such as a drive	er's license;	
☐ A written list of your current medica	ations with the dosages you are cu	ırrently taking; and
☐ Co-payment (if required by your ins	surance plan).	
Should you need to reschedule or car allow us the courtesy of offering your		us at least twenty-four hours in advance as to other patient.
Thank you for choosing St. Joseph's/Co	andler Physician Network for your	healthcare needs.
Appointment Information:		
Appt Date:	Appt Time:	Provider Name:



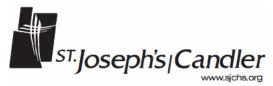
# Patient Registration Form

Patient Information												
Last Name	Fi	rst Name			М		Prefe	erred Nar	ne			
Mailing Address					City					State		Zip Code
Home Phone	Ce	ll Phone		Wor	k Pho	one		Birthd	ate (MM/			der at Birth ∕ale □ Female
Preferred communication refills, & test results □ V			Rx	Marital  Divo		us □ Single □ Widow		Married	Social	Security I		
Employer Name						ion/Job Title						ne 🗆 Part-time s needed)
Employer Address					City					State Zip Code		
Guarantor Information (R	esponsi	ible party - skip if s	ame as	above)								
Last Name	First N				М		Rela	tionship t	o Patien	t		
Address					City					State		Zip Code
Home Phone		Cell Phone				Birthdate (I	MM/D	D/YYYY)	Social :	Security	Numbe	r
Emergency Contact												
Patient Relationship to En		cy Contact: □Sp	ouse	Last N	lame			Fir	st Name	1		М
Address					City					State		Zip Code
Home Phone Cell Phone				Work Phone								
Primary Insurance [	⊐ SELF	PAY (not insured)										
Primary Insurance Compa		,					Pol	icy ID Nur	mber#			
Coverage Start Date	Subscriber/Insured Name  Patient Relationship to Insured: ☐ Spouse ☐ Spouse ☐ Patient Relationship to Insured: ☐ Spouse ☐ S					□Spouse □Parent						
Group Number#	Group Name Subscriber Date of Birth			ate of Birth		Subscriber Social Security Number			ecurity Number			
Secondary Insurance												
Secondary Insurance Com	npany						Pol	icy ID Nur	mber#			
Coverage Start Date	ge Start Date   Subscriber/Insured Name   Patient Relationship to Insured:											
Group Number#	Gro	oup Name	Name Subscriber Date of Birth Subscriber Social Security Number			ecurity Number						
Rx History Consent and A	dvance	e Directive										
Indicate whether you cor prescription history from	nsent fo	or your provider	to view I Yes	,		Advance Di Do you hav				_		edical treatment:
Patient Portal	57.0011	554. 565.				_ = 0 , 3 a mav	2 3111				-5	<del></del>
You can choose not to ac strongly recommend that			nation, Opt O			Email Ad	dress	(Require	d for poi	rtal acces	SS):	



# Patient Registration Form continued

Additional Information								
Race: ☐ Asian ☐ Black ☐ Hispanic ☐ White ☐ Decline ☐ Other			oanic or Latino or Latino □ Decline		age: □ Eng line □ Oth		panish □ Sign Lang	juage
		TI-I IISPATIIC	or Latino Li Decime	LI Deci		CI		
Primary Care Provider Information  Primary Care "PCP" Name		Date of La	oct Vicit		Referred	Dv		
rimary care PCF Name		Date of La	ast visit		Referred	Бу		
IF THE PREFERRED FACILITY IS NOT DESIGNATED THE PATIENT WILL BE RESPONSIBLE FOR PAYME		IE PATIENT,	ALL TESTS WILL BE SI	ENT TO	ST. JOSEP	H'S /CAN[	DLER FACILITIES AN	D
Lab: ☐ St. Joseph's/Candler (preferred) ☐ LabCorp ☐ Quest ☐ Other	X-ray:		h's/Candler (preferred)		erred Hosp andler Hosp		Joseph's Hospital her	
Pharmacy Information								
Pharmacy Name (Primary)			Phone			Fax		
Address		City	l		State		Zip Code	
Mail Order Pharmacy Information								
Mail Order Pharmacy Name			Phone			Fax		
Address		City	l		State		Zip Code	
Authorization to Treat, Obtain Medication Hist	ory, &	Assignmen	t of Benefits					
care providers and staff of SJ/C Physician Netwincludes obtaining medication history. I hereby request that payment of authorized benefits I medical information to my insurance carrier or pay outstanding balances within 90 days of not	oy certi be mad third-p tificatio	fy that, to t de to SJ/C F party payer on of the am	he best of my knowl hysician Network an to facilitate processir	edge, a d authong my ir	all stateme orize SJ/C I nsurance c	nts conta Physician Iaims. I ur	ined hereon are tr Network to release nderstand that failu	ue. I e any are to
Please print your name and sign below:								
Printed Name					Date			_
Signature of Patient or Personal Represent	ative				Relat	ionship		_



# Financial Agreement and Policies

## **Appointments**

We believe that our patient's time is valuable and every effort is made to keep your waiting time to a minimum. If you are unable to keep your appointment, please notify the office as soon as possible. This courtesy allows us to give appointments to another patient. If you do not cancel your appointment 24 hours prior to the scheduled appointment time a No-Show fee will be charged to your account. If you have 3 or more No Shows within a 12-month period you could be discharged from the practice.

# Financial Policy

- Your Insurance Card(s) and a picture ID will need to be presented each time you visit our practice to assure we have the most recent information. If an insurance card is not provided, payment for services will be collected prior to being seen.
- Co-payments must be paid <u>prior</u> to seeing the health care provider on the date service is rendered. Self-pay and uninsured patients will be required to pay a deposit prior to being seen. Patients are responsible for their deductibles or charges not reimbursed by insurance.
- It is understood that returned checks made payable to this office for insufficient funds, stop payments or other reason for non-payment will be assessed a \$30.00 NSF fee for which the patient will be held responsible.
- Patients with no financial ability to pay St. Joseph's/Candler charges will be screened for eligibility under Medicaid and other state programs and/or evaluated against established guidelines for financial assistance.

## Patient Portal

The patient portal allows patients to manage their personal health information at their own convenience. You will be able to securely and confidentially exchange non-emergent messages with our practice, request prescription refills, request and keep track of appointments, view referrals to specialists, view lab and imaging results and update your contact information.

# Prescription Refills

Please contact your pharmacy directly for more expedient prescription refills. Please allow your pharmacy up to 48 hours to process your refill request. Note that prescriptions will not be refilled after hours, on weekends, or holidays. Some prescriptions cannot be refilled if you have not seen your health care provider within the last 3-6 months. If you have mail service prescriptions, please allow 7-10 business days for the necessary forms to be completed.

# Test Results

You must have an appointment for lab tests and a lab order from your provider. Your health care provider will review your test results and notify you via voice message, letter, or message sent to your patient portal. If you have not heard from us within 7 days, please contact the office.

## Referrals and Prior Authorizations

Most insurance plans require a patient to be seen by their primary care provider prior to seeing a specialist. If your insurance plan requires a prior authorization you must verify your insurance has approved the visit before seeing the specialist. Otherwise, you will be responsible for any incurred charges.

### Medical Records

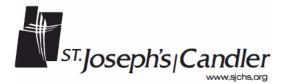
Please note that requests for any health information cannot be processed without a signed medical record release from the patient or legal representative. Please allow up to 7 business days for your request to be processed. A fee may be charged for this service.

Please print your name and sign below:		
Printed Name	 Date	-
Signature of Patient or Personal Representative		_



# HIPAA Compliant Authorization for Release of Health Information

I hereby authorize SJ/C Physicia	n Network t	o release OR receiv	e the followi	ng information	from the	health records of:
Patient Name:		DO	B:		SSN:	
To Be Released To:						
First and Last Name		Relationsh	nip	Date of B	irth	Phone Number
Information to be Released:						
☐ Entire Record	□ Lab Resu	ults	□Nursing	Notes	□Demo	ographics
☐ Emergency Room Notes		ical Results	☐ Physiciar			cation Records
For the Purpose of:						
☐ Anything on behalf of the patie	ent					
☐ Creating/Changing/Canceling a	ppointments					
☐ View or correct demographic in	nformation to	include signing in on	my behalf			
<ul><li>Receive documents containing signed by me.</li><li>Picking up prescriptions/forms</li></ul>			ion) on my be	ehalf with an auth	norization fo	or release of information
<ul><li>□ Speaking to SJ/C Physician Net behalf.</li><li>□ Other:</li></ul>	work staff reg	arding my PHI includii	ng but not lim	nited to billing and	d insurance	e information on my
I understand that I can revoke th Candler Physician Network or in a been released by relying upon this	manner desc	cribed in the Notice o	of Privacy Pra			
I PLACE NO LIMITATIONS ON HIST FOR ALCOHOL, DRUG ABUSE OR ACQUIRED IMMUNE DEFICIENCY (A	DEPENDENCY	, PSYCHIATRIC OR PS				
The physician's office listed above	may not cond	ition treatment, paym	ent, on the sig	gning of this auth	orization, ι	unless allowed by law.
I understand that I am waiving my may be re-disclosed by the rece above. I understand that this Relea	ving party. I	hereby authorize th	ne entity liste	d above to rele	ase the sa	id information described
Please print your name and sig	n below:					
Printed Name				Da	te	
Signature of Patient or Persona	l Representa	ative		 Re	lationship	



# Patient Consent to Contact

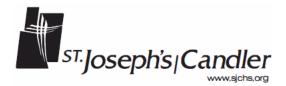
By providing a telephone number, I expressly consent and authorize SJ/C Physician Network, any practitioner or clinical provider as well as any of their related entities, agents, or contractors including but not limited to schedulers, marketers, advertisers, debt collectors, and other contracted staff (collectively referred to herein as "Provider") to contact me through the use of any dialing equipment (including a dialer, automatic telephone dialing system, and/or interactive voice recognition system) and/or artificial or prerecorded voice or message. I expressly agree that such automated calls may be made to any telephone number (including numbers assigned to any cellular or other service for which I may be charged for the call) used by or associated with me and obtained through any source including but not limited to any number I am providing today, have provided previously, or may provide in the future in connection with the medical goods and services and/or my account. By providing this express consent, I specifically waive any claim I may have to the making of such calls, including any claim under federal or state law and specifically any claim under the Telephone Consume, Protection Act, 47 U.S.C. § 227. By providing a telephone number, I represent that I am the subscriber or owner or have the authority to use and provide consent to call the number.

By providing a telephone number I expressly consent to the receipt of text messages from Provider at any telephone number (including numbers assigned to any cellular or other service for which I may be charged for the call) used by or associated with me and obtained through any source including but not limited to any number I have provided previously or may provide in the future in connection with my account. By providing this express consent, I specifically waive any claim I may have for the making of such calls, including any claim under federal or state law and specifically and claim under the Telephone Consumer Protection Act, 47 U.S.C. § 227. By providing a telephone number, I represent that I am the subscriber or owner or have the authority to use and provide consent to call the number.

By providing my email address now or at any time in the future in connection with the medical goods and services provided and/or my account, I expressly opt-in to the receipt of email communications from Provider for or related to the medical goods or services provided, my account, and other services such as financial, clinical, and education information including exchange news, changes to health care law, health care coverage, care follow-up, and other health care opportunities, goods, and services. By providing this express consent, I specifically waive any claim I may have for the sending of such emails, including any claim under federal or state, and specifically any claim under the CAN-SPAM Act. 15 U.S.C. § 7701, et seq. By providing an email address, I represent that I am the subscriber or owner or have the authority to use and provide consent to contact the email address.

I understand that providing a telephone number and/or email address is not a condition of receiving medical services. I also understand that I may revoke my consent to contact at any time by directly contacting Provider or using the opt-out method that will be identified in the applicable communication. I also understand that it is my responsibility to notify Provider immediately of any change in telephone number or email address.

Please print your name and sign below:	
Printed Name	 Date
Signature of Patient or Personal Representative	



# Patient Request for Health Information

HEALTH INFORMATION	MANAGEMENT DEPARTMEN	ΙΤ					
☐ St. Joseph's Hospital 11705 Mercy Blvd. Savannah, GA 31419 P: 912.819.2477 F. 912.819.2136	☐ Candler Hospital 5353 Reynolds St. Savannah, GA 31405 P: 912.819.6767 F. 912.819.6664	Doctor Address Phone	☐ Physician Network (Primary Care, Ob/Gyn, Specialty)  Doctor  Address  Phone  Fax				
Patient Information:							
Name		Date of Birth	1				
Address		City	State Zip				
What records do you ne  Date of Service							
☐ Abstract	☐ Emergency Room Record	☐ Radiology Reports	☐ Therapy Notes/Reports				
☐ Demographics	☐ Cardiac Cath, Echo, EKGs	☐ Radiology Images	☐ Pathology Slides				
☐ Dictated Reports	☐ Laboratory Reports	☐ Medication Admin Record	☐ Physician Office Notes/Forms				
How would you like your  Paper Email Email A	records delivered?	☐ In-person pick up	☐ Patient Portal				
How would you like your	records delivered?	☐ Self ☐ Personal	Representative				
Recipient Name		Phone					
Mailing Address		Email Address					
Please print your name a	and sign below:						
Printed Name			Date				
 Signature of Patient or P	Personal Representative		 Relationship				



CL70013 (02/2023)



# Joint 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. <u>Please review it carefully.</u>

St. Joseph's/Candler Health System is committed to protecting the privacy and safeguarding the security of your protected health information. This Joint Notice describes the privac practices of SJ/C and each of the SJ/C entities that participate in our "organized health care arrangement" (collectively referred to herein as "SJ/C" or "We"), including without limitation St. Joseph's Hospital, Candler Hospital, each Hospital's Medical Staff, our affiliated physician practices and Hospital Based Physician Practices providing services in Anesthesiology, Radiology, Pathology, the Emergency Rooms and Hospitalists. Each of the SI/C providers that comprise the organized health care arrangement are presenting this document as their joint Notice of Privacy Practices. SJ/C providers that participate in the organized health care arrangement may share medical information with each other for treatment, payment, or health care operations as described in this Notice.

SJ/C is committed to protecting the privacy of your identifiable health information, known as "protected health information" or "PHI." We are required by law to provide you with you with this joint Notice of our legal duties and privacy practices regarding PHI and to abide by the terms of the Notice currently in effect.

## How We May Use or Disclose Your Health Information

For Treatment. We may use and disclose your PHI for medical treatment or services. SJ/C uses or discloses your PHI to healthcare professionals, who require access to your PHI for treatment. For example, your PHI may be disclosed to facilities and providers not affiliated with SJ/C that are involved in your treatment.

For Payment. We may use and disclose your health information to others for purposes of receiving payment for treatment and services that you receive. For example, a bill may be sent to you or a third-party payor, such as an insurance company or health plan. The information on the bill may contain information that identifies you, your diagnosis and treatment or supplies used in the course of treatment.

For Health Care Operations. We may use and disclose health information about you for operational purposes. For example, your health information may be disclosed to members of the medical staff, risk or quality improvement personnel and others to: evaluate the performance of our staff; assess the quality of care and outcomes in your case and similar cases; learn how to improve our facilities and services; and determine how to continually improve the quality and effectiveness of the healthcare we provide. This includes sending information to a

third-party to conduct research on patient satisfaction and effectiveness of the services performed.

**Appointments.** We may use your information to provide appointment reminders or information about treatment alternatives other health-related benefits and services that may be of interest to you.

**Fundraising.** We may use limited PHI to contact you regarding charitable support or communications about SJ/C or its affiliates. All charitable support will be used to improve the healthcare services, expand patient programs and purchase state-of-the-art technology for SJ/C. You have the right to opt out of such fundraising communications at any time. If you sign an authorization form for any purpose, you may revoke it, in writing, at any time, except to the extent that action has been taken in reliance on the authorization.

Required by Law. We may use and disclose information about you as required by law. For example, SJ/C may disclose information for the following purposes: for judicial and administrative proceedings pursuant to legal authority; to report information related to victims of abuse, neglect or domestic violence; and to assist law enforcement officials in their law enforcement duties.

**Public Health.** Your health information may be used or disclosed for public health activities such as assisting public health authorities or other legal authorities to prevent or control disease, injury, or disability, or for other health oversight activities. These oversight activities include, for example, audits, investigations, inspections and licensure. These activities are necessary for the government to monitor the health care system, government programs and compliance with civil rights laws.

**Research.** We may use your health information for research purposes as allowed by law. The Institutional Review Board will review the research proposal and established protocols to ensure the privacy of your health information.

**Health and Safety.** Your health information may be disclosed if there is a potential serious threat to the health or safety of you or any other person as allowed by law.

Health Information Exchange (HIE). We may participate in certain HIEs in which your PHI is electronically shared in a secure and confidential manner with other health care providers involved in your care. Participation in the HIE is voluntary and you may elect to opt-out. If you choose to not participate in an HIE, your PHI will not be available for access through such HIE; however, it may



remain available for access through other mechanisms if permitted or required by applicable law.

**Individuals Involved in Your Care.** We may release health information about you to a friend or family member who is involved in your medical care or payment for your care or to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

Facility Directory Purposes. We may include certain limited information about you in a facility directory while you are a patient, such as your name, location in the facility, general condition (e.g., fair) unless you object to us doing so.

Additional Uses and Disclosures. As permitted by law, we may disclose your PHI to organ and tissue donor organizations, correctional institutions, coroners, medical examiners and funeral directors, workers compensation agents, or military command or national security authorities.

Other Uses. Other uses and disclosures will be made only with your written authorization and you may revoke the authorization except to the extent SI/C has taken action in reliance on such.

## Your Rights to Privacy:

- You have the right to request a restriction on certain uses and disclosures of your information. However, the organizations listed above are not required to agree to a requested restriction.
- You have the right to obtain a paper copy of the Notice of Privacy Practices upon request to the Privacy Official or a member of the organization.
- You have the right to inspect and obtain a copy of your health record as allowed by state and federal regulations.
- You may also request an amendment to your health record as allowed by state and federal regulations.
- You may also request communications of your health information by alternative means or at alternative locations.
   For example, by sending information to a P.O. Box instead of your home address.
- You may revoke your Authorization to use or disclose health information except to the extent that action has already been taken by providing written notice to the Health Information Management Department at SJ/C, 5353 Reynolds Street, Savannah, Georgia 31405.
- You may also receive an accounting of disclosures made of your health information as provided by federal regulations by sending a written request to the Health Information Management Department at the address listed above.
- If you have a concern or complaint about your privacy rights, you may direct the concern or complaint in writing to:

St. Joseph's/Candler Privacy Official 5353 Reynolds Street Savannah, Georgia 31405 (912) 819-5290

You may also contact the Department of Health and Human Services, if you believe your privacy rights have been violated. You will not be retaliated against for filing a complaint.

# Our Obligations Under This Joint Notice.

We are required by law to maintain the privacy of protected health information and to provide you with a Notice of our legal duties and privacy practices with respect to the protected health information.

# Changes to This Notice.

We reserve the right to change this Notice, and 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. If this notice is revised or changed, we will post the current Notice with its effective date. An up-to-date copy of this Notice is available electronically on our websites. You are entitled to a copy of the Notice currently in effect.

#### Communications.

Please note that as communications over the internet can be intercepted, e-mail and text messaging may not be a secure method of transmitting information. By providing us with your email address or mobile phone number, you understand these risks and consent to us communicating with you via e-mail or text message about your treatment or payment for your care.

Effective Date: April 14, 2003 Last Revised: December 2023