LOURDES
Riverside Surgical

Patient Registration Form

Site: GSR

Patient Information

Name________________________ M F

DOB__________ Race_________________

Address______________________________

City_____________ State_____ Zip_______

SS#__________________________________

Phone (h)_____________ (c)____________

What is your primary language?__________

e-mail_______________________________

Physician_____________________________

Marital Status (√ one)
Married Single Widow(er)
Divorced Legally separated
Other____________________________

Retired Yes No **If yes,** Date________

Patient's Employer

Employer_____________________________

Phone (w)_________________ ext________

Primary Insurance Information

Primary Insurance______________________

Policy #______________ Group #________

Insured Name__________________________

Insured DOB________ SS#______________

Relationship to Insured to Patient:
Self Spouse Parent

If Patient is a Minor

Minor patients (under 18 years of age) must be accompanied by a parent or guardian, or anyone designated on the Authorization Form filled out by the responsible party.

Legal Guardian_________________________

DOB__________ Race_________________

Address______________________________

Same as Patient? Yes

City_____________ State_____ Zip_______

SS#__________________________________

Relationship to patient:
Mother Father Guardian

Employer_____________________________

Phone (w)_________________ ext________

Emergency Contact

Name:________________________________

Address______________________________

Same as Patient? Yes

City_____________ State_____ Zip_______

Employer_____________________________

Phone (w)_________________ ext________

Mobile (c)____________________________

Secondary Insurance Information

Secondary Insurance___________________

Policy #______________ Group #________

Insured Name__________________________

Insured DOB________ SS#______________

Relationship - Insured to Patient:
Self Spouse Parent

Signature____ Date:___________ Time:_______
(Patient or Parent / Guardian if patient is a minor)

Re-Order # Net 030 10/21/13 (PB001, 2 hole)

Weight Loss Surgery Program Questionnaire

Name:____________________________

DOB:_________ MR:_____________

OR

Label

Intake Questionnaire	
Name:	Medical Insurance Company:
Address:____________________________ City:______________________________ State:_______________ Zip:__________	Policy #: Insured Name:
Home Phone: ( ) Can we call you at this number? ☐ Yes ☐ No	Work Phone: ( ) Can we call you at this number? ☐ Yes ☐ No
Cell Phone: ( ) Can we call you at this number? ☐ Yes ☐ No	Gender: ☐ Male ☐ Female Birthdate: ____/_____/_______ Age:_______
Primary Care Physician:	Referring Provider:
Primary Care Physician Address: Address:____________________________ City:______________________________ State:_______________ Zip:__________	How did you hear about our program? ☐ Friend ☐ Bulletin/Advertisement ☐ Referred by Healthcare Provider ☐ Other (please specify) ____
Emergency Contact:	Emergency Contact Phone: ( )

Your Weight History		
Weight at 18 years:	Weight 5 years ago:	Current weight:
Height:	Were you overweight at a child? ☐ Yes ☐ No	

Indicate if any of the following family members have a history of being overweight or obesity:

Father ☐ Yes ☐ No   Mother ☐ Yes ☐ No

Number of sisters:__________ How many have a history of being overweight:__________

Number of brothers:________ How many have a history of being overweight:__________

Name:______________________

DOB:________ MR:____________
OR
Label

Your Weight History (continued)

Have you tried any of the following to lose weight in the past? Please be specific about programs and give dates.

☐ Exercise ☐ Low Calorie Diet ☐ Liquid (very low calorie) diet

☐ Prescription Diet Drugs (√ all that apply)
☐ Phentermine ☐ Fenfluramine ☐ Fen/Phen ☐ Redux ☐ Meridia ☐ Xenical

☐ Over the Counter Drugs (e.g., Dexatrim)

☐ Formal Diet Program (Weight Watchers, Jenny Craig, OA):________________________
____

☐ Hypnosis ☐ Psychological Counseling/Behavior Modification

☐ Herbal Supplements:____

☐ Other: (specify) ____

Please describe your eating habits

* Do you eat when you are upset or nervous? ☐ Yes ☐ No
* Do you have a "sweet tooth" (i.e., eat a lot of candies or pastries)? ☐ Yes ☐ No
* Do you tend to binge eat (i.e., eat very large amounts at one sitting)? ☐ Yes ☐ No
* Do you tend to wake up at night to eat? ☐ Yes ☐ No

Your Social History

How many alcoholic beverages do you drink per week?
(1 drink = 1 oz. hard liquor, 4 oz. wine or 8 oz. beer)

☐ None ☐ 8-14 drinks/week ☐ < 1/week
☐ 15-21 drinks week ☐ 2-7 drinks/week ☐ > 22 drinks/week

Do you smoke cigarettes?
☐ Former ☐ Never ☐ Yes, currently

If yes, how many years have you been smoking?_________
Usual number of cigarettes/day ☐ < 5 ☐ 5-14 ☐ 15-29 ☐ 30+

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow
How many people do you live with?______

Do you have any children: ☐ No ☐ Yes If yes, please specify:____________________

LOURDES

Weight Loss Surgery Program Questionnaire

Name:______________________________

DOB:__________ MR:______________

OR

Label

Your Medical History				
Please indicate if you have or had any of the following:	**Yes**	**No**	**Explain:**	**Family History? Who?**
Blurred vision				
Glaucoma				
Hearing loss				
Angina (chest pain related to heart disease)				
High blood pressure				
High blood pressure during pregnancy (females)				
High cholesterol				
Heart attack				
Blockage of the arteries in the heart				
Heart Failure				
Problems with heart valves				
Stroke				
Sleep apnea (snoring, waking tired, breathing problems at night)				
Breathing problems (asthma, COPD, Emphysema, shortness of breath)				
Heartburn				
Reflux (GERD)				
Gallbladder disease or gallstones				
Ulcers				
Liver disease (hepatitis, NASH, etc)				
Stomach problems (constipation, diarrhea, blood in stool)				
Irritable bowel syndrome				
Hernia				
Abnormal urination (loss of control, blood in urine)				
Menstrual irregularity (females)				
Infertility (females)				
Kidney disease				
Arthritis				
Pain in back, hip, knee, ankle, and / or foot				
Skin disease (rash, eczema, psoriasis)				
Itching hives				

Name:____________________________

DOB:_________ MR:_____________
OR
Label

Your Medical History (continued)	**Yes**	**No**	**Explain:**	**Family History? Who?**
Diabetes (insulin dependent or non-insulin dependent)				
Diabetes during pregnancy (females)				
Excessive hair growth				
Thyroid disease				
Regular headaches / migraines				
Seizures				
Psychiatric treatment (anxiety, depression, suicide history, other)				
Substance abuse				
Mental retardation				
Anemia				
Bleeding disorder				
Blood clots in arms, legs or lungs				
History of blood clots				
Unexplained bruising				
Swelling of lymph nodes				
Leg pain and cramping in legs				
Arm or leg swelling				
HIV / AIDS				
Cancer				
Radiation treatment				
Regular fevers or fatigue				
Difficulty walking, dressing or bathing due to your weight				
Weakness (fatigue, dizziness, fainting)				

Do you have any other medical problems or a history of any other medical problems?

If yes, please specify:____

____

____

____

____

Name:______________________

DOB:_________ MR:____________
OR
Label

Your Surgical History

Have you had any of the following surgical procedures?	**Yes**	**No**	**Explain:**
* Surgery to produce weight loss			
* Removal of the gallbladder			
* Removal of the appendix			
* Surgery on the spleen			
* Surgery on the stomach, intestines or colon other than for weight loss? If yes, please specify:			
* Surgery for hernia			
* Surgery on the uterus, ovaries or fallopian tubes (hysterectomy, tubal ligation, c-section)			
* Surgery on the spine			
* Surgery on joints			
* Surgery of the lungs			
* Heart surgery			
* Thyroid surgery			
* Pregnant			
* Pap smear			
* Mammogram			

Do you have a history of any other surgery? If yes, please specify: ____________________
____
____

Have you ever been hospitalized for a reason other than surgery?
If yes, please specify: ____
____
____

Have you ever a colonoscopy or gastroscopy?
If yes, MD:____

Where:____

Weight Loss Surgery Program Questionnaire

Name:________________________

DOB:________ MR:____________
OR
Label

Current Medications: (include prescription, herbals/supplements and over-the-counter)					
What Medication?	How Much?	How Often?	Route? (oral, injection)	Reason Why?	What Physician prescribed it?

Do you have any medication or environmental allergies? ☐ Yes ☐ No If yes, specify:

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

Do you take antidepressant medications? ☐ Yes ☐ No

Your Activity Level

Please check your consistent level of activity for the past 2 months:

How often do you perform physical activity?

☐ 6-7 times/week ☐ 3-5 times/week ☐ 1-2 times/week
☐ A few times/month ☐ Less than once/month

How long do you perform in physical activity?

☐ Over 30 minutes ☐ 20-30 minutes ☐ 10-20 minutes ☐ Under 10 minutes

Your Present Status

In general, would you way your health is:

☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

Does your health now limit the activities you might do during a typical day?
If so, how much? ____

Does your health limit moderate activities, such as moving a table, pushing a vacuum cleaner, bowling or playing golf.

☐ Yes, limited ☐ Yes, a lot ☐ Yes, a little ☐ No, not limited at all

Does your health limit climbing several flights of stairs

☐ Yes, limited ☐ Yes, a lot ☐ Yes, a little ☐ No, not limited at all

Name:______________________________

DOB:__________ MR:______________
OR
Label

Your Present Status (continued)

During the past 4 weeks:
Have you had any of the following problems with your work or other regular daily activities as a result of your **physical** health?

Accomplished less than you would like ☐ Yes ☐ No
Were limited in the **kind** of work or other activities ☐ Yes ☐ No

Have you had any of the following problems with your work or other regular daily activities as a result any **emotional** problems (such as feeling depressed or anxious?

Accomplished less than you would like ☐ Yes ☐ No
Didn't do work or other activities as **carefully** as usual ☐ Yes ☐ No

How much did pain interfere with your normal work (including both work outside the home and housework)?
☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

Please give the one answer that comes closest to the way you have been feeling and how things have been with you.

How much time during the past 4 weeks . . .	All the time	Most of the time	A good bit of time	Some time	A little time	No time
Have you felt calm / peaceful	☐	☐	☐	☐	☐	☐
Did you have a lot of energy	☐	☐	☐	☐	☐	☐
Have you felt downhearted / blue	☐	☐	☐	☐	☐	☐

During the past 4 weeks, how much has your physical health or emotional problems interfered with your social activities (like visiting friends, relatives, etc.)?
☐ All the time ☐ Most of the time ☐ A good bit of time ☐ Some time ☐ A little time ☐ None

Your Safety

Have you ever felt unsafe or been afraid of anyone? ☐ Yes ☐ No
Has anyone ever hurt or threatened to hurt you or someone else that you care about?
☐ Yes ☐ No

____ __________ __________
MD Reviewed Signature Date Time

Label
or
Name DOB
MR#

Patient Preference Regarding Release of Health Information to Individuals Involved in Their Care or Family Members

Patient Name: (Please print)____DOB:______________

_____ I do not want the Practice/Lourdes/my health care provider to release any information concerning my medical care to any individual involved in my care or to members of my family.

_____ The Practice/Lourdes/my health care provider or their staff may verbally release the following information concerning my medical care:

☐ Test results only ☐ Diagnosis only ☐ Any information concerning my medical care

☐ Other:____

Individual(s) to whom the information may be released:

☐ Spouse
____
First Name Last Name Phone

☐ Son(s) / Daughter(s)
____
First Name(s) Last Name(s) Phone

____
First Name(s) Last Name(s) Phone

☐ Step-Son(s) / Step-Daughter(s)
____
First Name(s) Last Name(s) Phone

____
First Name(s) Last Name(s) Phone

☐ Significant Other
____
First Name Last Name Phone

☐ Other
____
First Name Last Name Phone

Relationship to patient:_________________________________

This form will remain in effect until written notice to change is received.

____ _________________ _________________
Patient Signature Date Time

____ _________________ _________________
Witness Date Time

Label

Conditions of Admission

Patient Name: ____________________________ **DOB:** ______________

MR#:___________________ **Social Security Number:** ________________

Date of Service: ______________ **Account #:**________________________

HIPAA Information

Visitors	Yes	No
Directory	Yes	No
Clergy	Yes	No

Patient presented with: **Photo ID:** ______________ **Other ID:**______________ **No ID**

Consent to Hospital Admission or Medical / Dental Treatment:

I hereby consent to medical care and treatment to include routine diagnostic and therapeutic procedures by Our Lady of Lourdes Memorial Hospital Inc.. **I have been** informed that Our Lady of Lourdes Memorial Hospital, Inc. and its medical staff are participating in the educational programs for Medical students, nursing students and allied health personnel approved by the State of New York. As part of these programs, students will be participating in the care of patients at Lourdes Hospital when approved by the attending physician. I understand that I will have the right to express to my provider at the time of any of my visits my wishes to consent to the participation of students in my care.
I consent to the Hospital to dispose of all specimens taken for laboratory or pathological examinations.
I consent to photographing or recording/filming, which will be used for internal purposes only.
I understand that I have the right to rescind consent before photographs/video recordings are actually used.

Assignment of Benefits: In consideration of the services provided by Our Lady of Lourdes Memorial Hospital, Inc. to the patient identified above, I hereby assign and transfer to the Hospital all hospital and medical provider benefits payable and related rights existing under the insurance policies that I have identified or will identify in connection with this admission or medical treatment (but not to exceed the amount of the Hospital's charges for this period of hospitalization or other amounts as may be provided by an agreement between the Hospital and my insurance company). I consent to and direct the insurance company to pay all such benefits to the Hospital and appropriate medical providers. I understand that this assignment does not relieve me of any responsibility I may have for payment of charges not paid by the insurance company, unless otherwise provided by the terms of an agreement between the insurance company and the Hospital. This also applies to any newborn child.

Consent of Release Claim Information: I hereby consent to Our Lady of Lourdes Memorial Hospital, Inc., its associates and agents, and members of its Medical Staff to release and disclose all information that has been and that will be received, recorded or compiled by any or all of them concerning my (or the patient's) hospitalization or medical care and treatment to any appropriate persons for the purpose of evaluating claims for payment or reimbursement for charges and expenses under any public, Title XVIII of the Social Security Act (Medicare/Medicaid), or private reimbursement, which may have a bearing on the benefits payable by or on behalf of any such person. I hereby give consent for Our Lady of Lourdes Memorial Hospital, Inc., its associates and agents to act on my behalf in completing claims forms.

Pre-Certification: I understand that my insurance policy may require compliance with a utilization review program to make certain that health care benefit funds are expended when justified.
I understand that it is the utilization review program's responsibility to review proposed elective admissions and anticipated courses of treatment.
I understand that if the utilization review program determines that the admission is necessary and appropriate and issues certification, the benefits of my health plan will be made available to me in accordance with the terms of my policy. However, if certification is denied, health care benefits may be withheld.

Pre-Certification (continued): I understand that pre-certification may be the responsibility of the patient or financially responsible party and his or her physician.

I understand that Our Lady of Lourdes Memorial Hospital, Inc. is willing to admit as requested by my physician**.**

Label

I also understand that I may be financially responsible for all hospital charges incurred as a result of this admission should the utilization review program refuse to certify that the admission is appropriate, or should the certification effort occur too late to be valid.

I understand that to protect myself from unnecessary personal financial losses, I must review my obligations with my insurance company, utilization program, and personal physician without delay.

About Your Billing: In addition to the bill you receive from Our Lady of Lourdes Memorial Hospital, Inc., you may receive a bill directly from the physician for professional services rendered. If you receive services from Radiology, Anesthesiology, or Pathology, you will receive a bill for the professional component of your treatment. Although Our Lady of Lourdes Memorial Hospital, Inc. may be a provider in your insurance network, the physician may or may not be a participating provider. This may affect your coverage level for professional services. Please contact your Members Services Representative with your plan for coverage determination.

When you receive your bill, please review the statement to determine where inquiries should be directed. The professional services listed below are not performed by Our Lady of Lourdes Memorial Hospital, Inc. Specific inquiries regarding professional billing for these services should be directed to the following offices:

- Millenium Medical Imaging, PC (800) 235-0045
- Riverside Associates in Anesthesia PC (607) 722-7264
- Twin Tier Pathology (607) 798-5219
- Exigence (ED) (800) 611-0750

Self-Pay: I understand that I am financially responsible for charges or any unpaid balances for the patient account listed above. Please check one of the following statements:

( ) I acknowledge that the above named patient has no known existing coverage under the Medicaid program.

( ) I acknowledge that the above named patient has applied for medical coverage under the Medicaid program and has not received a determination of eligibility from the Department of Medical Assistance.

I hereby release Our Lady of Lourdes Memorial Hospital, Inc. from all liability resulting from loss or damage to any personal effects retained by me on admission or subsequently received by me while I am a patient in this Hospital/Emergency Department. This includes prosthetic devices (denture, limbs, etc.), jewelry, eyeglasses, electrical devices, clothing, and any other personal items.

I acknowledge that the insurance information I have provided is correct and in force at the time of this service. I understand this does not guarantee payment for services rendered.

____

Patient Signature or Patient Representative (State Relationship to Patient) Date Time

____

Name or Signature of Insurance Policy Holder Date Time

____

Witness Date Time

(If required) Interpreter:____

(Signature) (Print Name with Date /Time)

Joint Notice of Privacy Practices

Effective Date:
September 23, 2013

169 Riverside Drive
Binghamton, NY 13905
(607) 798-5111
www.lourdes.com

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.

WHO THIS NOTICE APPLIES TO

Lourdes and the practitioners who practice at Lourdes participate in an organized health care arrangement whereby they follow the same privacy practices, and are presenting you with this document as a joint Notice.

Participants include:

- All non-employed doctors and other health care practitioners who take care of you while you are at Lourdes Hospital, Lourdes Mobile Vans, Lourdes walk-in clinics, Lourdes Primary Care Sites and other Lourdes facilities;
- Any health care provider allowed to write in your medical chart;
- All Lourdes departments and units;
- Any volunteers we allow to help you while you are in the hospital or receiving care at a Lourdes site; and
- All Lourdes employees, staff, and other personnel.

OUR RESPONSIBILITIES

Lourdes takes the privacy of the health information entrusted to us seriously, as both an ethical and a legal obligation. We are required by law to:

- Maintain the privacy of health information.
- Provide you with this Notice of Privacy Practices ("Notice"), which tells you about our duties and practices with respect to protecting health information.
- Abide by the terms of the Notice that is currently in effect.
- Notify you following a breach of unsecured health information that affects you.

HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION

The following categories describe different ways Lourdes may use and disclose your health information without your written authorization. Health information is most often used and disclosed to provide treatment, to obtain payment for treatment, or for health care operations. We will provide an example of the types of uses covered by these categories. Not every use or disclosure in a category will be listed. References to "you" and "your" information include your child's information, when appropriate:

- **For Treatment** - Lourdes may use and disclose health information to provide treatment, health care or other related services. Health information may be used by or disclosed to doctors, nurses, aides, or other healthcare providers who are involved in taking care of you. Additionally, Lourdes may use or disclose health information to manage or coordinate treatment, health care or other related services. *For example, we may use or disclose health information about you for treatment purposes such as when you are referred to a specialist for care or when we send a prescription to a pharmacy to be filled for you.*
- **For Payment** - Lourdes may use and disclose health information to bill and collect for the treatment and services we provide to you. We may send health information to your insurance company or other third party payer for payment purposes. *For example, we may use and disclose health information about you for payment purposes such as when we send claims to your HMO for payment or to find out whether proposed treatment is covered.*
- **For Health Care Operations** - Lourdes may use and disclose health information for health care operations. These uses and disclosures are necessary to run Lourdes and to maintain and improve the quality of health care we provide.
  For example, we may use and disclose health information about you for health care operations purposes such as accreditation renewals, quality improvement activities, and teaching purposes.
- **Hospital Directory** - Lourdes may include limited information about you in the hospital directory while you are a patient at Lourdes.

This information includes your name, location in the hospital, your general condition (e.g., fair, stable, etc.) and your religious affiliation. The directory information may be disclosed to people who ask for you by name, except for your religious affiliation, which may only be disclosed to clergy members. You have the right to not have your information included in the hospital directory ("opt-out"). *To opt-out of the hospital directory, we ask that you make this request during patient registration.*

- **Individuals Involved in Your Care or Payment for Your Care** - Lourdes may disclose to your family member, relative, close personal friend or other person identified by you, health information that is directly relevant to that person's involvement with your care or payment for your care. *Lourdes will not share this information with these individuals if we are aware of your desire not to have this information shared.*
- **Appointment Reminders and Health-Related Benefits or Services** - We may use health information to provide you with appointment reminders, information about treatment alternatives, or information about other health care services or benefits we offer.
- **Fundraising** - We may use or disclose health information for the purpose of raising funds to help support Lourdes' Mission. *You have the right to opt-out of receiving fundraising communications. Please contact the Lourdes Foundation at 607-798-5684 for more information on how to opt out.*
- **Research** - Under certain circumstances, Lourdes may use and disclose health information for research purposes. For example, a research project may involve comparing the health and recovery of all individuals who receive one medication to those who receive another. All research projects are subject to a special approval process.
- **Immunization Records** - Lourdes may disclose immunization records to a school where you are or will be a student, if the school is required by law to have proof of immunizations for admission purposes. *In some instances, Lourdes will first obtain your verbal or written permission to make this disclosure.*
- **For Public Health Purposes** - Lourdes may disclose health information for public health activities. For example, public health activities include: preventing and controlling disease, injury or disability; reporting births and deaths; and reporting defective medical devices or problems with medications.
- **About Victims of Abuse** - Lourdes may disclose your health information to notify the appropriate government authority if we believe you have been the victim of abuse, neglect or domestic violence. *We will only make this disclosure if you agree, or when required or authorized by law.*
- **Health Oversight Activities** - Lourdes may disclose health information to a health oversight agency for health oversight activities authorized by law. These activities include audits, investigations, licensure and disciplinary actions, and related activities to monitor the health care system, governmental benefit programs, and compliance with civil rights laws.
- **Judicial and Administrative Proceedings** - Lourdes may disclose health information in response to a subpoena, court order, or administrative order, if certain requirements are met.
- **Law Enforcement** - Lourdes may release health information to law enforcement if the disclosure is required by law, necessary to identify or locate a suspect or missing person, about criminal conduct at Lourdes, about a victim of crime under certain circumstances, and in certain emergency situations.
- **To Avert a Serious Threat to Health or Safety** - Lourdes may use and disclose health information when Lourdes believes it is necessary to prevent a serious threat to the individual's health and safety or the health and safety of the public or another person. Any disclosure would only be to someone able to help prevent or lessen the threat, or to law enforcement authorities.
- **Coroner, Medical Examiners, and Funeral Directors** - Lourdes may disclose health information to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death, or other duties authorized by law. Lourdes may disclose health information to a funeral director, consistent with law, to permit the funeral director to carry out his/her duties.
- **Organ Donation Purposes** - Lourdes may disclose health information to organ procurement organizations and others engaged in procurement, banking or transplantation of cadaveric organs, eyes, or tissue, for the purposes of facilitating organ donation and transplantation.

- **Military and Veterans** - If you are a member of the armed forces, we may release your health information as required by military command authorities. We may also release health information about foreign military personnel to the appropriate foreign military authority.
- **National Security and Intelligence Activities** - Lourdes may release health information to authorized federal officials for intelligence, counterintelligence and other national security activities as authorized by law.
- **Protective Services for the President and Others** - Lourdes may disclose health information to authorized federal officials so they may provide protection to the President or other authorized persons, or for the conduct of special investigations authorized by law.
- **Inmates** - If you are an inmate or in the custody of a correctional institution or law enforcement, Lourdes may disclose health information to the correctional institution or law enforcement official for treatment and safety purposes.
- **Worker's Compensation** - Lourdes may disclose health information as authorized by and to the extent necessary to comply with worker's compensation laws or laws relating to similar programs.
- **As Required by Law** - Lourdes will disclose health information when required to do so by federal, state or local law.

SHARED MEDICAL RECORD/HEALTH INFORMATION EXCHANGE

Lourdes participates in arrangements of health care organizations which have agreed to work with each other, to facilitate access to health information that may be relevant to your care. For example, if you are admitted to a hospital on an emergency basis and cannot provide important information about your health condition, these arrangements will allow us to make your health information from other participants available to those who need it to treat you at the hospital. When it is needed, ready access to your health information means better care for you. We store health information about our patients in a joint electronic medical record with other health care providers who participate in the arrangement. You may contact Lourdes' Privacy Officer if you have any questions.

SPECIAL RESTRICTIONS UNDER STATE AND OTHER FEDERAL LAWS

We will also comply with all other applicable state and federal laws. *For example, under state law, there are more limits on when HIV and AIDS information may be disclosed. Under other federal law, there are more limits on when drug or alcohol abuse treatment information may be disclosed.* We abide by all applicable state and federal laws.

OTHER USES AND DISCLOSURES

Any other uses and disclosures of health information not covered by this Notice or the laws that apply to us will be made only with your Authorization.

DISCLOSURES THAT REQUIRE YOUR AUTHORIZATION

An Authorization is a special written permission from you that grants authority to Lourdes to use or disclose your health information.

- We must obtain your Authorization to use or disclose psychotherapy notes. Psychotherapy notes may only be used for limited purposes, such by the treating professional. Disclosures are permitted only as required by law, for certain health oversight activities, or to avert a serious threat to health or safety.
- We must obtain your Authorization to use or disclose health information for marketing purposes, or for disclosures that constitute the sale of medical information.
- If you provide us an Authorization to use or disclose your health information, you may revoke that Authorization, in writing, at any time. If you revoke your Authorization, we will no longer use or disclose health information about you for the reasons covered by your Authorization.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

You have the following rights regarding health information we maintain about you:

- **Right to Request Restrictions** - You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. **In most cases, we are not required to agree to your request.** If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. *We must agree to your request if you are paying or have paid for a service out-of-pocket, in-full and you are asking us not to submit information about that service to your health plan. We will say "yes" to your request unless a law requires us to share that information. You must identify the date of service and the exact information that you want restricted.* We ask that you make this request **prior to the time of service** to the Director, Health Information Management Services (Medical Records) at 169 Riverside Drive, Binghamton, NY. 13905.
- **Right to Request Confidential Communications** - Typically, we communicate with you regarding your health care either by calling your home phone or sending mail to your home address. You have the right to request that we communicate with you in an alternative way or at a certain location. To request confidential communications, we ask that you make your request **in writing** to your health care provider at the location where you received services. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.
- **Right to Access** - In most cases, you have the right to access your health information by requesting to inspect and/or obtain a copy of your health information, with limited exceptions. We ask that your request be made in **writing** to the Director, Health Information Management Services (Medical Records) at 169 Riverside Drive, Binghamton, NY. 13905. You may request the copy of your health information be provided in a summary format. You may also request the copy be provided on paper ("hard copy") or in an electronic form or format. Lourdes will also transmit a copy of your health information to another person designated by you in writing. Lourdes may charge reasonable fees for copies.
- **Right to Request Amendments** - You have the right to ask us to amend your health information. To request an amendment, we ask that your request be made in **writing** and submitted to your health care provider at the location where you received services. In addition, you must provide a reason that supports your request. We may deny your request in certain circumstances, such as if the information was not created by us, or we believe the information is already accurate and complete. If we deny your request, you may appeal the denial.
- **Right to an Accounting of Disclosures** - You have the right to request a list of certain disclosures that we have made of your health information. We ask that your request be made in **writing** to the Director, Health Information Management Services (Medical Records) at 169 Riverside Drive, Binghamton, NY. 13905. Your request must state a time period which may not be longer than six years.
  The first list you request within a twelve-month period will be free. For additional lists, during the same twelve-month period, we may charge you for the reasonable costs of providing the list.
  We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.
- **Right to Notification of a Breach** - Lourdes must notify you if your unsecured protected health information has been the subject of a breach.
- **Right to a Paper Copy of this Notice** - You may ask us to give you a copy of this Notice at any time. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy of this Notice. You may also obtain a copy of this Notice at our web site at www.lourdes.com.

CHANGES TO THIS NOTICE

We reserve the right to make changes to this Notice. We reserve the right to make the revised Notice effective for health information we already have, as well as any information we receive or create in the future. The Notice will contain the current effective date. We will post a copy of the current Notice in our locations and on our website. The Notice is also available to you upon request.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with Lourdes or with the Secretary of the Department of Health and Human Services. To file a complaint with Lourdes, contact our Privacy Officer. **You will not be penalized for filing a complaint.** To ensure we have sufficient information, we ask that complaints be submitted in writing. **If you have any questions about this Notice, please contact:**

Lourdes
Attn: Privacy Officer
169 Riverside Dr. Binghamton, NY. 13905
607-798-5335

Office for Civil Rights
U.S. Department of Health and Human Services
Jacob Javits Federal Building
26 Federal Plaza - Suite 3312
New York, NY 10278

Acknowledgement of Receipt of Joint Notice of Privacy Practices

____, **has received a copy of the**

Print Patient Name

Lourdes Joint Notice of Privacy Practices.

Signature of Patient Date Time

__If person signing this form is other that patient:__

Signature of Personal Representative Date Time

Relationship to Patient

If you are returning this signed form by mail, please send to:

Lourdes
Attn: HIMS
169 Riverside Drive
Binghamton, NY 13905

www.lourdes.com