CHI St. Joseph Health

Patient Registration Form

Patient Legal Name: _____
Last Name First Name Middle Initial

Address: _____
Street or Box City Zip Code

Phone: (Primary)_____(Cell)_____(Work)_____

Driver's License #:_____ DOB: _____

Email: _____

Spouse Name: _____ DOB: _____

Gender: ☐ Male ☐ Female SS#: _____

Marital Status: ☐ Single ☐ Married ☐ Life Partner ☐ Legally Separated
☐ Divorced ☐ Widow/Widower ☐ Unknown

Employment Status: ☐ Full Time ☐ Part time Employer: _____

Student: ☐ Full Time ☐ Part time ☐ N/A School: _____

Race: ☐ American-Indian or Alaska-Native ☐ White ☐ Asian ☐ Native Hawaiian
☐ Black or African-American ☐ More than One Race

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino Language Spoken: _____

Religion: _____ Referred By: _____

Insurance: _____ Patient Insurance ID Number: _____

Subscriber Name: _____ Subscriber Date of Birth: _____

Emergency Contact Name:_____Relationship: _____

Daytime Phone: _____ Evening Phone: _____

Name of Preferred Local Pharmacy: _____ Telephone: _____

Pharmacy Address: _____

Mail Order Pharmacy: _____

How do you prefer to receive communications from our clinics (check all that apply):

☐ Phone Call ☐ Text ☐ Patient Portal/Email ☐ Letter

Primary Care Physician: _____Telephone:_____

Please complete if PATIENT is a student or minor:

Mother's Name:_____ DOB: _____ SS#:_____

Address: _____ Phone: _____

Father's Name:_____ DOB: _____ SS#:_____

Address: _____ Phone: _____

CHI St. Joseph Medical Information Form

Date:_____

Patient Name:_____ DOB:_____

Medical History: (Please check if you have or had any of the following)

□ Abuse (physical/mental/sexual/verbal, etc.)	□ Cholesterol (high)	□ Intestinal Disease
□ Abnormal Pap	□ Chronic pain	□ Kidney or Bladder Problems
□ Alcoholism/Drug use	□ Depression/mental disorder	□ Lung Disease
□ Anemia	□ Diabetes	□ Osteoporosis
□ Anxiety/nerves	□ Epilepsy/Seizures	□ Serious Accident/Injury
□ Arthritis	□ Genetic Diseases	□ Sexual Disease/VD
□ Asthma	□ Glaucoma/Cataract	□ Stroke
□ Allergies	□ Gout	□ Thyroid Disease
□ Bleeding disease	□ Headaches/Migraine	□ Tuberculosis
□ Blood transfusion	□ Heart Disease	□ Ulcers/Stomach Disease
□ Blood clots	□ Hepatitis (any)	
□ Cancer/Tumor	□ High blood pressure	

Do you have an advance directive on file? ☐ Yes ☐ No

OB/GYN History

Date of last pap smear:_____
Have you ever had an abnormal pap? ☐ Yes ☐ No If yes, date and results_____
Date of last mammogram:_____
Have you ever had an abnormal mammogram? ☐ Yes ☐ No If yes, date and results_____
History of hysterectomy? ☐ Yes ☐ No If yes, date and why?_____
Do you have an OB/GYN? ☐ Yes ☐ No If yes, then who?_____
Age of first period:_____ Date of last period:_____
Pregnancies: Total #___ Full Term___ Miscarriages___ Abortions___ Premature___ Tubal___
Complications:_____

Surgical History

Date or Age	Surgery

Hospitalizations

Date or Age	Reason/Details

Family History (place a checkmark where applicable)

	Alive (A) Deceased (D)	Diabetes	Hypertension	Heart Disease	Stroke	Mental Illness (Type?)	Cancer (Type?)	Unknown	Other
Father									
Mother									
Sibling(s)									
Son(s)									
Daughter(s)									
Paternal Grandfather									
Paternal Grandmother									
Maternal Grandfather									
Maternal Grandmother									
Paternal Uncle									
Paternal Aunt									
Maternal Uncle									
Maternal Aunt									

Other (please explain)_____

Social History

Are you a current smoker? ☐ Yes ☐ No If no, then have you ever smoked? ☐ Yes ☐ No
How many per day?_____ For how many years?_____
What year did you quit?_____ Are you interested in quitting? ☐ Yes ☐ No
Do you use other tobacco products, and if so, what?_____ _____

Do you drink alcohol? ☐ Yes ☐ No How many drinks per day?____ How many times a week?_____
Do you use any recreational drugs, and if so, what?_____
Have you ever had an alcohol or drug problem in the past? ☐ Yes ☐ No

Are you sexually active? ☐ Yes ☐ No ☐ Single Partner ☐ Multiple Partners
Any history of sexually transmitted infections, and if so, what?_____

Do you drink caffeine? ☐ Yes ☐ No How much per day?_____

Occupation:_____

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Do you have children? ☐ Yes ☐ No What are their ages?_____

Social Functioning Assessment (Primary Care Visits Only)

1. During the past 4 weeks, was someone available if you needed and wanted help? For example, if you felt very nervous, lonely, or blue, got sick and had to stay in bed, needed someone to talk to, needed help with daily chores, or needed help just taking care of yourself. □ Yes, as much as I wanted □ Yes, quite a bit □ Yes, some □ Yes, a little □ No, not at all □ I choose not to answer

2. Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living? (Check all that apply) □ Yes, it has kept me from medical appointments or getting my medications. □ Yes, it has kept me from non-medical appointments, meetings, work, or getting things I need. □ No. □ I choose not to answer.

Additional Information

Any other family members attend our clinics, and if so, who?_____

Who was your prior primary care physician and location? When was your last visit?

_____

What would you like to discuss with the physician today?

_____

_____

Current Medications (prescription, over-the-counter, vitamins, supplements, or herbals)

Medication Name	Dosage	How often?
Example: Name of drug	5 mg	One pill twice a day or one pill daily

Allergies (medications, x-ray dyes, other substances, seasonal, etc.)

Name of Substance	Reaction
Example: Name of drug	Hives, swelling

Health Maintenance/Screening/Special Tests (list the dates of your last studies/exams)

Study/Exam	Approximate Date/Year	Abnormal?
Physical/Annual exam		
Bone density test		
Colonoscopy		
EKG		
Stress test		
PSA (Prostate-specific antigen)		
Dental exam		
Eye exam		

Immunizations (list the dates when you received the vaccines)

Immunization	Approximate Date/Year
Flu	
Pneumonia	
Tetanus	
Tdap (tetanus plus whooping cough)	
Hepatitis B	
Gardasil	
Tuberculosis screening ☐ Pos ☐ Neg	
Shingles	

Would you be interested in receiving these today? ☐ Yes ☐ No

Review of Systems (Circle the items that you are CURRENTLY experiencing)

General
Fever
Chills
Night sweats
Weight loss
Weight gain
Fatigue

Eyes
Vision changes
Eye redness
Eye drainage
Eye pain
Corrective lens

Ear, Nose, & Throat
Hearing changes
Ear pain
Ear drainage
Nasal congestion
Runny nose
Postnasal discharge
Nose bleeds
Sore throat
Voice changes

Cardiovascular
Chest pain
Palpitations/heart racing
Shortness of breath
Shortness of breath when lying flat
Swelling in the legs/feet
Leg/foot pain
Varicose veins

Pulmonary
Shortness of breath at rest
Shortness of breath with walking
Cough
Wheezing
Snoring

Gastrointestinal
Abdominal pain
Nausea
Vomiting
Heartburn/indigestion
Difficulty/pain with swallowing
Change in bowel movements
Diarrhea
Constipation
Blood in the stool

Male Genitourinary
Pain with urination
Frequent urination
Urgent need to urinate
Abnormal urine stream
Urinary incontinence
Blood in the urine
Erection problems
Discharge from the penis

Female Genitourinary
Pain with urination
Frequent urination
Urgent need to urinate
Urinary incontinence
Blood in the urine
Vaginal discharge
Pelvic pain
Painful periods
Irregular periods

Musculoskeletal
Neck pain
Back pain
Joint pain
Muscle pain

Integumentary
Rash
Itching
Dry/sensitive skin
Breast masses/lumps
Nipple discharge

Neurological
Headache
Dizziness
Numbness
Weakness
Tingling
Memory loss

Psychiatric
Depression
Anxiety
Mania/euphoria
Mood swings
Hallucinations

Endocrine
Excessive urination
Excessive thirst/drinking
Excessive hunger
Feeling cold all the time
Feeling hot all the time

Hematology/Lymph
Swollen lymph nodes
Excessive bruising
Excessive bleeding
Anemia
History of transfusion

Allergy/Immunology
Lip/facial swelling
Hives
Environmental allergies
Seasonal allergies
Food allergies

Consent for Admission and Registration

CHI St. Joseph Health

INTRODUCTION: CHI St. Joseph Health is hereinafter referred to as "the Hospital." Any and all Physicians providing care and treatment including consultation during the course of my admission to the Hospital are hereinafter referred to as "the Physicians."

1. CONSENT TO TREATMENT: I have a condition requiring examination, diagnosis, and treatment and hereby consent to and authorize such customary care including but not limited to x-ray, laboratory, routine diagnostic tests and therapeutic procedures ("Services") performed by my admitting and treating Physician, which may or may not be employed by the Hospital and his or her assistants or designees, including personnel employed by the Hospital. I understand that photographs, videotapes, digital or other images may be recorded to document my care, and I consent to this and for the Hospital to retain ownership rights to these images. A separate consent for photography form will be obtained for disclosure of any images outside of the Hospital that identify me and are used for purposes such as education and marketing. I agree to the supervised participation of health care students (e.g., medical students, nursing students, interns, residents, and non-Physician clinical students) in my care. I understand that such care may involve risks and that no guarantees have been made to me concerning the results of this treatment or examination. I further understand that I have the right to make decisions concerning my health care, including the right to refuse medical and surgical procedures/treatment. For any notice or authorization referenced herein, a copy of this form can be used in place of the original.

2. ASSIGNMENT OF BENEFITS: The undersigned authorizes, whether he/she signs as agent or as Patient, billing by and direct payment to the Hospital (or to the Physicians providing Services to the Patient at Hospital and who do hereafter accept such assignment and bill directly for their Services) of any insurance benefits (as defined below) and any governmental program benefits otherwise payable to or on behalf of the Patient or the undersigned for this Hospitalization (including Physician Services attributable to this Hospitalization) or for these outpatient Services, including emergency Services if rendered, at a rate not to exceed the Hospital's (or Physician's) regular charges. The term "insurance benefits" as used herein includes all insurance benefits including but not limited to health insurance, accident, worker's compensation benefits and motor vehicle insurance, casualty insurance, medical health coverage and uninsured or underinsured insurance. It is understood by the undersigned that he/she is financially responsible for an charges. In consideration of goods and Services provided, he/she gives Hospital an irrevocable assignment to any and an rights, title and interest he/she has in all insurance benefits or governmental program benefits payable to him/her or in his/her behalf for Services provided by Hospital, Physician or their employees and others working under an arrangement with the Hospital (or its Physicians). He/she directs all insurance companies, health plans, governmental agencies and programs and their agents or contractors, and attorneys to make such payment directly to Hospital (or to such Physicians at the address specified in billing invoices). Any credit balance resulting from benefit payments or other sources may be applied to any other account owed by the Patient or the undersigned.

3 FINANCIAL RESPONSIBILTY: I understand that if my Insurer denies all or any part of Hospital's charges for any reason, or if I have no insurance, I will be personally and fully responsible for payment of Hospital's charges. I agree, whether I sign as the Patient, Legal Representative, or Guarantor for the Patient, that in consideration of the Services rendered that I individually obligate myself and/or the Patient to pay the account of Hospital in accordance with the established rates and payment policy of the Hospital. If I believe I qualify for financial assistance, I must notify the business office. The undersigned authorizes the transfer of any overpayment on this account to be applied to any account which the undersigned is a patient, guarantor, or otherwise legally responsible.

4. PRE-ADMISSION CERTIFICATION AND RELEASE OF INFORMATION: I authorize payment of my insurance benefits to the physicians and Hospital named on my insurance claim form. I further authorize release of information required by any Insurer or third-party payor regarding any claim made relating to me. I understand that I am financially responsible for charges not paid by my insurance company and/or third party payor. I understand that it is my responsibility to provide notice to and to obtain pre-admission certification from any Insurer or third-party payor if required under the terms of my relationship with an insurance carrier or any third party payor. I will be personally responsible for all or part of the cost of hospitalization or professional Services if payment of the same is denied by reason of my failure to provide notice or obtain certification or authorization.

5. CERTIFICATION/AUTHORIZATION FOR MEDICARE OR MEDICAID BENEFITS: I certify that the information given by me in applying for payment under Title XVIII (Medicare) or Title XIX (Medicaid) of the Social Security Act or under any other governmental health care program or from any other third-party payor is correct. Furthermore, I authorize anyone having medical or other information about me pertinent to my qualification for Medicare or Medicaid programs or benefits to release to and to secure from the Social Security Administration, the State Medical Assistance Program or to other agencies or entities administering the Medicare and Medicaid programs, or to intermediaries or carriers any information needed for this or a related Medicare or Medicaid claim. I request that payment of authorized benefits be made on my behalf directly to the Hospital, to the Physicians, and to any other health care provider qualifying for reimbursement for such medical care and treatment, including consultations, provided to me.

6. AUTHORIZATION FOR THE RELEASE OF INFORMATION: I authorize the Hospital to release to any person, corporation, or any other entity any diagnostic therapeutic information including any diagnosis and treatment involving ALCOHOL AND SUBSTANCE ABUSE COUNSELING, BEHAVIORAL OR MENTAL HEALTH SERVICES, GENETIC TESTING, SEXUALLY TRANSMITTED & INFECTIOUS DISEASES, AIDS and HIV status, as applicable, and as may be necessary to determine health care benefits entitlement for me under any insurance policy or other type of health care benefits plans or as may be appropriate for the purpose of analysis or research regarding reimbursement of Physicians and other health care providers. I authorize the Hospital to process payment claims for health care Services provided. I agree to cooperate and execute such other authorizations and releases for the above purposes as deemed necessary by the Hospital upon the Hospital's request. I understand the Hospital may utilize information in my medical record that is necessary for research or quality improvements purposes.

It is my intent that the use of the information furnished is prohibited for any purpose other than stated above and that the recipient is prohibited from re-disclosing information protected by law to any other party to whom disclosure is not necessary or required for the purpose stated above.

I understand that I have the right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to the medical records department. I understand that this revocation will not apply to the extent that Hospital has already taken action in reliance on this authorization. This authorization is valid until all terms and conditions, including payment of this admission are met.

I understand that authorizing the disclosure of this health information is voluntary. I understand I can refuse this release as it does not assure treatment, payment, enrollment or eligibility for benefits. I understand I may inspect or obtain a copy of the information to be used or disclosed, as provided in 42 CFR 164.524. I understand any disclosure of information carries with it the potential for an un-authorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the medical records department at (979) 776-2524.

Patient or Legal Representative Signature	Printed name & relationship of person signing on behalf of patient	Date

7. INDEPENDENT STATUS OF PHYSICIANS: I recognize that not all Physicians, and health care providers including, but not limited to, Certified Registered Nurse Anesthetists, Radiologists, Emergency Room Physicians, Anesthesiologists, Physical, Occupational and Speech Therapists, residents or medical students (under the supervision of Physicians and/or residents) who provide Services to me during this admission are employees or agents of the Hospital. Such individuals are INDEPENDENT CONTRACTORS who are granted privileges to use the Hospital for private Patients and bill separately for their Services. In addition, I understand that the Hospital is not responsible for nor does it assume any liability for the acts or omissions of any such independent contractors.

8. TESTING FOR INFECTIOUS DISEASES: I understand that, if testing for Human Immunodeficiency Virus ("HIV") or any other blood borne infectious disease is ordered by a Physician for diagnostic purposes, I will be asked to sign a separate written informed consent. I also understand that, in the case of exposure of a health care provider or first responder (such as an emergency worker, fire fighter or police officer) to my bodily fluids, although I will be informed of the right to consent to testing for HIV or other infectious diseases transmitted by bodily fluids, in most cases, rests may be performed on previously gathered bodily fluid samples or a court order may be obtained to compel such testing. Information concerning the fact that a test was ordered and the results of such test will remain confidential and be disclosed by the Hospital only as permitted by law.

9. PERSONAL EQUIPMENT AND VALUABLES: I understand that the Hospital does not accept responsibility and will not reimburse me for the loss of money, jewelry, eyewear, hearing aids, dentures, clothing or other personal property or valuables which I bring to the Hospital. I take full responsibility for such items and agree to release the Hospital from any and all liability from damage, loss or theft of such items unless, as applicable, the items are deposited in the Hospital safe for safekeeping. I also understand that I must inform the admissions clerk or a nurse if I bring any electrical equipment to the Hospital (e.g. ventilators; Bipap machine, Cpap machine) and adhere to Hospital policies regarding its use. I assume full responsibility for such electrical equipment and for any injury caused by the use of the electrical equipment brought from home.

10. SEMI-PRIVATE AND PRIVATE ACCOMMODATIONS DIFFERENTIAL: I understand that Medicare and other payers do not pay the difference in the cost between a private and semi-private room when use of a private room is not ensured by medical necessity for isolation purposes. If I request a private room at any time during the Hospital stay, I, hereby agree that the difference in the cost between a semi-private and private room will be my responsibility to pay.

11. WORKER'S COMPENSATION AUTHORIZATION: If my admission to the Hospital is a result of a work related injury, I hereby waive any privilege I may have with the Hospital, or other healthcare provider, and I hereby authorize these providers to provide the worker's compensation administrator, any information, including, but not limited to, the right to inspect and copy all of my medical records related to my injury or to my past relevant medical history. In the event there is a dispute about the compensability of my claim or worker's compensation benefits, and if my employer is not specifically determined by a Court of the Department of Labor to be responsible for worker's compensation medical expenses for the condition or injury that is the basis of my admission, I agree to be personally responsible for all such expenses. I further agree that if my worker's compensation claim is settled with my employer on a disputed basis without a specific finding that such is compensable as a worker's compensation injury, I (or my attorney if I am represented), will withhold sufficient funds from any settlement to pay all amounts owed to the Hospital for treatment of the condition which is the basis for this admission and I hereby grant an assignment to the Hospital for payment of all such expenses under such circumstances.

12. GENERAL DUTY NURSING: Except in the special care units, the Hospital provides only general nursing care. The Patient and/or Representative should consult with the Patient's attending Physician(s) to determine if the Patient's condition requires continuous or special duty nursing care. If so, such special duty nursing care must be arranged by the Patient, or Legal Representative and the Hospital shall in no way be responsible for failure to provide the same and is hereby released from any and all liability from failure to provide special duty nursing care and from any liability arising from any acts or conduct of anyone providing special duty nursing care.

13. COMMUNICATIONS CONSENT: By providing my cell, landline, or any other number(s), I expressly consent to receiving communications from Hospital, its staff, its contractors, collection agents, and others, at any numbers I provide or that are later acquired for me. These parties may use this information to contact me by live agent, voice mail, text message, using an auto dialer or other computer assisted technology, pre-recorded message(s), or by any other form of electronic communication for any purpose including, but not limited to, appointment and follow-up health care reminders, scheduling, my account(s), assignment of benefits, and/or financial responsibility. I understand that depending on my phone plan I could be charged for these calls or text messages. I agree to provide new number(s) if my number(s) change. Providing these numbers is not a condition of receiving healthcare services.

14. PHARMACY HEALTH INFORMATION EXCHANGE: I consent to Hospital to obtain my medication history information electronically through a pharmacy health information exchange (e.g., Surescripts, E-Prescribe). Physicians and providers access the information to know what medications I am taking so that they can treat me appropriately and avoid adverse drug reactions.

Advance Directive: An Advance Directive allows you to tell your physician or give someone else the authority to tell your physician what kind of care you would like to receive if you become unable to make medical decisions for yourself.

Do you have an advance directive? ____ Yes ____ No

If Yes:	**If No:**
Have you provided a copy to the Hospital? ____Yes ____ No Please indicate which type(s) of directive you have provided: _____ Directive to Physicians / Living Will _____ Out-of-Hospital DNR Order _____ Medical Power of Attorney _____ Declaration for Mental Health Treatment	Would you like to receive information to formulate an Advance Directive? _____ Yes _____No **If Yes, information given:** _____ Yes _____No

CHI St. Joseph Health

Directory Information Disclosure: I, the undersigned, understand that should I/the patient be hospitalized, that information about my/the patient's health care is kept in my/the patient's medical record and is kept private.

Please choose and initial by one of the following options:

Option A: _____ I authorize the Hospital to use the following information to maintain a directory of individuals in the Hospital: my name, my location in the Hospital, my condition (as described in general terms such as critical, poor, fair, good or excellent), and my religious affiliation. I authorize the Hospital to disclose such information to members of the clergy or to persons who ask for me by name (with the exception of my religious affiliation).

Option B: _____ **NO INFORMATION / NO DISCLOSURE:** I do not want anyone to know that I am a patient in this facility. I do NOT authorize release of any information regarding my admission or treatment. **I understand that mail, flowers, visitors and phone calls will be refused on my behalf. I understand that friends and family will not be allowed to visit me.**

Patient Identification Number: I further understand that the Hospital has a policy to allow the release of patient related medical information and updates **DURING CURRENT HOSPITALIZATION ONLY** to individuals authorized by the patient to receive this information. For this purpose, a **Patient Identification Number (PIN)** is available to the patient who can decide to share this number at his/her discretion with family and/or friends so the Hospital staff can share information about patient location and condition with those designated by the patient who have been provided the PIN information. Otherwise, the information will be restricted to those individuals who do not have the PIN information.

REPRESENTATION/SIGNATURE: My signature below indicates that I have read fully and understand this document or have had it read to me and that I (As the Patient or the Patient's Legal Representative, or Guarantor) hereby accept and agree to the terms of this Conditions on Admission.

Check all that apply prior to signature.

☐ I received a copy of the Rights & Responsibilities of Patients.
☐ I received the Important Message from Medicare.

_____ _____
Signature of Patient, Legal Representative or Legal Guarantor Date Time

_____ _____
If other than Patient, Relationship of above Signatory to Patient Reason, if other than Patient (Incompetent, Minor, etc.)

_____
Witness Signature

_____
Interpreter Name/Number (if applicable)

Hospital does not discriminate on the basis of race, color, national origin, sex, religion, age or disability in employment or providing Services.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES: I have received a copy of the Hospital's Notice of Privacy Practices and have indicated so by signing here.

_____ _____
Signature of Patient /Legal Representative/Guarantor Date

OR

* The undersigned certifies that he or she provided a Notice of Privacy Practices to the Patient, but that the Patient either was unable to or unwilling to acknowledge receipt of such Notice of Privacy Practices for the reason noted below.

_____ _____
Name of Hospital Representative Seeking Acknowledgement* Date

Reason for Lack of Acknowledgment: _____

PATIENT RIGHTS

I acknowledge that I have been given information and instructions regarding my Patient Rights. My Patient Rights include, but are not limited to, the right to make medical decisions, including the right to accept or refuse medical treatment, participate in my plan of care and receive care in a safe setting, free from verbal or physical abuse or harassment. I also understand that if I have questions regarding my rights, I should ask an employee of this facility for assistance.

Patient's Bill of Rights:

I, as the patient, have a right to:

- receive reasonable access to care and treatment that is medically indicated as necessary and within the facility's capability and mission, regardless of race, creed, sex, age, national origin, or sources of payment for care;
- receive considerate, respectful care at all times and under all circumstances, with recognition of personal dignity;
- be free from all forms of abuse or harassment;
- be free from restraints and seclusion in any form when used as a means of coercion, discipline, convenience for the staff, or retaliation;
- personal and informational privacy, within the scope of the law;
- expect that a family member or representative of my choice and my own physician will be notified promptly of my admission to the facility;
- the presence of a support individual of my choice, unless the individual's presence infringes on others' rights, safety, or is medically or therapeutically contraindicated;
- designate visitors subject to limitations that are clinically necessary;
- expect reasonable safety insofar as the facility practices and environment are concerned and request additional assistance when I have a concern about my condition;
- know the identity and professional status of individuals providing service;
- obtain, from the practitioner responsible for coordinating care, complete and current information concerning diagnosis (to the degree known), treatment, and any known prognosis;
- means of communication with people outside the facility by means of visitors and by oral and written communication in my preferred language for discussing healthcare, and by access to an interpreter if language barriers exist;
- reasonably informed participation in decisions involving health care and receive information about experiments, research, or educational projects affecting my care and treatment; the patient has the right to refuse to participate in any such activity.
- consult with a specialist at my own request and expense;
- accept or refuse medical care to the extent permitted by law;
- receive an explanation if being transferred to another facility;
- request and receive an itemized and detailed explanation of my total bill for services when available;
- be informed of facility rules and regulations applicable to my conduct as a patient;
- participate in the consideration of ethical issues that arise during my care;
- formulate advance directives and appoint a surrogate to make health care decisions on my behalf as described above;
- receive appropriate assessment and effective management of pain.

I have the responsibility to:

- provide accurate and complete health information and to understand my plan of care;
- follow the plan of care developed by me and my healthcare team;
- accept responsibility for the outcomes of refusing treatment or for not following my agreed upon plan of care;
- fulfill my financial obligations;
- be considerate of the rights of others and follow the rules and regulations of this facility about patient care and conduct.

CHI St. Joseph Health
Medical Group
Insurance Network Information Notice

Dear Patient/Responsible Party:

State law requires healthcare providers to notify consumers of the insurance networks that they participate in. This CHI St. Joseph Health facility participates in, but not limited to, the following insurance networks.

Commercial

Aetna EPO, PPO, POS, Open Access	Great-West Healthcare	PHCS
Ambetter EPO, HMO	HealthSmart Preferred Care PPO	Provider Select PPO
Beech Street PPO	Humana Tricare Prime Remote, Standard	Three Rivers Provider Network PPO
Blue Cross Blue Shield Blue Essentials, PPO, POS	Independent Medical Systems PPO	TriWest VAPC3, VA
Cigna PPO, Open Access, HMO*, LocalPlus*	Molina Marketplace HMO	United HealthCare
Coventry/First Health PPO	MultiPlan PPO	USA Managed Care Organization PPO
FirstCare PPO, HMO*	Nexcaliber PPO	
Galaxy Health Network PPO	NX Health	

*HMO network participation is limited to plans offered in our local coverage area. HMO and other Limited Network plans offered by employers in surrounding areas may not be included in our local coverage area and would require prior authorization.

Medicare

Aetna Medicare Advantage HMO, POS, PPO	Human Medicare Advantage PFFS, PPO	United HealthCare Medicare Advantage PPO
Care Improvement Plus Administered by UHC	Molina Medicare Advantage Option, Options Plus, MMP	Traditional Medicare Part B

Medicaid

Amerigroup STAR, STAR+PLUS, CHIP	Molina STAR, STAR+PLUS, CHIP, CHIP Perinate	Superior STAR, STAR+PLUS, Foster Care, CHIP, CHIP Perinate
Blue Cross Blue Shield STAR, STAR+PLUS, STAR Kids, CHIP	RightCare STAR	Texas Medicaid

Workers' Compensation

Beech Street	Galaxy Health Network	Political Subdivision Workers Comp Alliance
CorVel	Injury Management Organization	Prime Health Services
Coventry	MultiPlan	Rockport Healthcare

Sports Injury

Health Special Risk	Lonestar Athletic Network	Texas Kids First

If you have questions regarding a bill from a CHI St. Joseph Health facility, please contact the appropriate Patient Financial Services department listed below.

- For Clinic Billing: (888) 275-9403 Monday-Friday, 8am-5pm
- For Hospital Billing: (979) 776-3952 Monday-Friday, 8am-5pm

In addition to services provided by this CHI St. Joseph Health facility, other caregivers may participate in caring for you or your family member. The caregivers listed below are not employees of this facility. They bill separately for the services they provide and they may not necessarily participate in the same insurance networks as this CHI St. Joseph Health facility.

If you have questions for one of these caregivers, please contact their office(s) directly for assistance at the numbers listed below:

Radiologists:	*Anesthesiologists:*	*Pathologists:*	*Hospitalists:*
Bryan Radiology Associates	American Anesthesiology of Texas, Inc	Brazos Valley Pathology	Sound
(979) 776-8291	(979) 776-4777	(866) 790-9722	(877) 636-7852

Above all – Thank you for choosing this CHI St. Joseph Health facility for your and your family's needs.

Sincerely,
CHI St. Joseph Health

Revised 4/7/2018

CHI St. Joseph Health
Imagine better health.℠

AUTHORIZATION TO INSPECT AND RELEASE PROTECTED HEALTH INFORMATION

PATIENT NAME:_____ **BIRTHDATE**:_____

ADDRESS:_____ **TELEPHONE NO:** (_____)_____

_____

_____

1. I hereby authorize CHI St. Joseph's Health to:

☐ Disclose/release the specified health information:

TO: _____

_____

_____

_____

Telephone No: (_____)_____

Fax No: (_____)_____

☐ Receive the specified health information:

FROM:_____

_____

_____

_____

Telephone No: (_____)_____

Fax No: (_____)_____

2. The following health information to be disclosed is maintained in the designated record set: (specify the exact information to be disclosed, including dates of service):

☐ Complete medical record Date(s) of Service_____
[OR the records marked below]

- ☐ Emergency Department Record
- ☐ Discharge Summary
- ☐ History & Physical Examination
- ☐ Consultation Reports
- ☐ Progress Notes
- ☐ Report of Procedure
- ☐ Pathology Report
- ☐ Heart Diagram
- ☐ Laboratory Tests
- ☐ Radiology Reports
- ☐ Physicians' Orders
- ☐ Nursing Notes
- ☐ OTHER
- ☐ (specify) _____

_____

☐ Diagnostic films/Digital Images (specify) _____

Please contact the Radiology Department regarding Imaging questions or concerns
Phone (979) 776-2532 or Fax (979) 776-2550

☐ Billing Records (specify) _____

3. For the purpose of: _____

4. If you are requesting copies of your own medical record, indicate here if you would prefer to receive via:
☐ Encrypted CD/DVD

(OVER)

ROIREQUEST

5. I understand that this information may include information relating to specific laboratory tests of HIV infection (Human Immunodeficiency Virus, the causative agent of AIDS) or the diagnosis of Acquired Immune Deficiency Syndrome (AIDS) or AIDS related conditions; treatment for drug or alcohol abuse; mental or behavioral health or psychiatric care, excluding psychotherapy notes.

6. I understand that CHI St. Joseph's Health may charge a fee for the costs associated with processing this request.

7. CHI St. Joseph's Health may deny this request to inspect and copy health information in certain limited circumstances, which are described in separate policies. If you are denied access, you may request that the denial be reviewed. Another licensed health care professional chosen by CHI St. Joseph's Health will review your request and the denial. The person conducting the review will not be the person who denied the request. CHI St. Joseph's Health will comply with the outcome of the review.

8. This authorization is given freely with the understanding that:

a) I may revoke this authorization at any time, except where information has already been released.
b) The revocation must be in writing and a form is available from the medical record department.
c) This authorization will expire 180 days from date of signature.
d) CHI St. Joseph's Health may not condition treatment or payment upon obtaining this authorization.
e) A photocopy or fax of this authorization is as valid as the original.
f) Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected.

_____
Signature of Patient

_____
Date

_____
Signature of Patient's Representative

_____
Representative's Printed Name

_____
Relationship to Patient

_____
Date

CHI St. Joseph Health STAFF

☐ **Verified identity of person picking up records.**

Date verified: _____ Name and Department: _____

CHI St. Joseph Health

Patient Name: _____

DOB: _____

Medicare Secondary Payer Questionnaire

PART I

1. Are you receiving benefits from a Federal Black Lung Program?
   ☐NO
   ☐**YES – Federal Black Lung will be primary payer for BL related claims**

2. Are services to be paid for by a Government research program?
   ☐NO
   ☐**YES – Research Program will be primary payer for related claims**

3. Has the Department of Veteran Affairs authorized and agreed to pay for services at this facility
   ☐NO
   ☐**YES – DVA will be primary payer for services**

4. Was the illness/injury due to a work related accident/condition?
   ☐NO
   ☐**YES – W/C is primary payer for claims related to accident/condition**

Obtain the following:

Name & Address of W/C Plan :	
Policy Number:	
Name & Address of Employer:	

If you answered NO to all of the questions above go to PART II

PART II

1. Was illness/injury due to a non worked related accident?
   ☐NO – Go to PART III
   ☐**YES – Date of accident**:_____

   Is No Fault insurance available**?**
   ☐**NO go to PART III**
   ☐**YES – No Fault is primary payer for related claims. Obtain the following**:

Name & Address of NO FAULT insurer :	
Claim Number:	

   Is LIABILITY insurance available?
   ☐NO go to PART III
   ☐**YES – Liability is primary payer for related claims. Obtain the following**:

Name & Address of NO FAULT insurer :	
Claim Number:	

PART III

1. You are entitled to Medicare based on:
   ☐AGE – Go to PART IV
   ☐Disability – Go to PART V
   ☐End-Stage Renal Disease – Go to PART VI

PART IV

1. Are you currently employed?
   ☐Yes:

Name & Address of Employer	

   ☐No:

Date of Retirement:	

   ☐No, never employed

2. Is your spouse currently employed?
   ☐Yes:

Name & Address of Employer	

   ☐No:

Date of Retirement:	

   ☐No, never employed

If you answered NO to both questions 1 & 2, Medicare is primary unless patient answered YES to questions in PART I or II. Do not proceed any further.

2. Do you have group health plan (GHP) coverage based on your own, or spouses current employment?
   ☐Yes, Both
   ☐Yes, Self
   ☐Yes, Spouse
   ☐**No –** ***Medicare is primary payer unless the patient answered yes in Part I or II.***

3. If you have GHP coverage based on your own current employment, does your employer that sponsors to the GHP employ 20 or more employees?
   ☐ Yes – GRP is Primary. Obtain the following:

Name & Address of GHP:	
Policy Number:	
Group Number:	

   ☐**NO –** ***Medicare is primary unless patient answered yes to questions in PART I or II***

4. If you have GHP coverage based on your spouse current employment, does your spouse's employer that sponsors to the GHP employ 20 or more employees?
   ☐ Yes – GRP is Primary. Obtain the following:

Name & Address of GHP:	
Policy Number:	
Group Number:	

   ☐**NO –** ***Medicare is primary unless patient answered yes to questions in PART I or II***

PART V

1. Are you currently employed?
   ☐Yes:

Name & Address of Employer:	

   ☐No:

Date of Retirement:	

   ☐No, never employed

2. Is your spouse currently employed?
   ☐Yes:

Name & Address of Employer	

   ☐No:

Date of Retirement:	

   ☐No, never employed

If you answered NO to both questions 1 & 2, Medicare is primary unless patient answered YES to questions in PART I or II. Do not proceed any further.

5. Do you have group health plan (GHP) coverage based on your own, or spouses current employment?
   ☐Yes, Both
   ☐Yes, Self
   ☐Yes, Spouse
   ☐**No –** ***Medicare is primary payer unless the patient answered yes in Part I or II.***

6. If you have GHP coverage based on your own current employment, does your employer that sponsors to the GHP employ 100 or more employees?

   ☐ Yes – GRP is Primary. Obtain the following:

Name & Address of GHP:	
Policy Number:	
Group Number:	

   ☐**NO –** ***Medicare is primary unless patient answered yes to questions in PART I or II***

7. If you have GHP coverage based on your spouse current employment, does your spouse's employer that sponsors to the GHP employ 20 or more employees?

   ☐ Yes – GRP is Primary. Obtain the following:

Name & Address of GHP:	
Policy Number:	
Group Number:	

   ☐**NO –** ***Medicare is primary unless patient answered yes to questions in PART I or II***

8. Are you covered under GHP on a family member other than a spouse?
   ☐ YES
   ☐ **NO –** ***Medicare is primary unless patient answered yes to questions in PART I OR II***

9. If you have GHP coverage based on a family member's current employment, does the employer that sponsors to the GHP employ 100 or more employees?

☐ Yes – GRP is Primary. Obtain the following:

Name & Address of GHP:	
Policy Number:	
Group Number:	
Name & Relationship of policy holder	

☐**NO –** ***Medicare is primary unless patient answered yes to questions in PART I or II***

PART VI

1. Do you have group health plan coverage?
   ☐ YES – Obtain the following GHP information for Self, Spouse or Other Family

Name & Address of GHP:	
Policy Number:	
Group Number:	
Name & Relationship of policy holder	
Name and Address of Employer	

   ☐**NO –** ***Medicare is primary unless patient answered yes to questions in PART I or II***

2. Have you received a kidney transplant?
   ☐NO
   ☐YES Date of transplant: _____

3. Have you received maintenance dialysis treatments?
   ☐ NO
   ☐Yes – Date dialysis started: _____

4. If you participated in a self dialysis program, the date training started - _____

5. Are you within the 30-month coordination period?
   ☐ NO
   ☐YES – Start Date: _____

6. Are you entitles to Medicare on the basis of either ESRD and age or ESRD and disability?
   ☐Yes
   ☐NO

7. Was your initial entitlement to Medicare (including simultaneous or dual entitlement) based on ESRD?
   ☐YES
   ☐NO

8. Does the working aged or disability MSP provisions apply (is GHP primary based on age or disability entitlement)?
   ☐YES
   ☐NO

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Witness Signature Date

CHI St. Joseph Health

Notice of
Privacy Practices

Effective date: 4/2003, Revised, 11/2014

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.

If you have any questions about this joint notice, please contact the Corporate Responsibility Privacy Office at (979) 776-5316 or write to 2801 Franciscan Drive, Bryan, TX 77802.

Definitions

Notice of Privacy Practices (The Notice) – a written notice in compliance with the requirements of Health Insurance Portability and Accountability Act (HIPAA), and the Health Information Technology for Economic and Clinical Health (HITECH) Act, enacted as part of the American Recovery and Reinvestment Act (ARRA) of 2009, made available from CHI St. Joseph Health to an individual or the individual's personal representative at the first delivery of service, or at the individual's next visit following a revision to the Notice, that describes the uses and disclosures of protected health information that may be made by CHI St. Joseph Health and the individual's rights and CHI St. Joseph Health's legal duties with respect to protected health information.

Protected Health Information (PHI) – individually identifiable health information that is transmitted or maintained in any form or medium, including electronic media. Protected health information does not include employment records held by CHI St. Joseph Health in its role as an employer.

CHI St. Joseph Health, an affiliate member of Catholic Health Initiatives (CHI), and other affiliated members of CHI participate in an Organized Health Care Arrangement (OHCA) in order to share health information to manage joint operational activities. A complete list of CHI affiliated members is available at **www.catholichealthinitiatives.org** by clicking on "Locations". A paper copy is available upon request. The CHI OHCA may use and disclose your health information to provide treatment, payment, or health care operations for the affiliated members and includes activities such as integrated information system management, health information exchange, financial and billing services, insurance, quality improvement, and risk management activities.

CHI St. Joseph Health including CHI St. Joseph Health Regional Hospital, CHI St. Joseph Health Bellville Hospital, CHI St. Joseph Health Grimes Hospital, CHI St. Joseph Health Madison Hospital, CHI St. Joseph Health Burleson Hospital, CHI St. Joseph Health Skilled Nursing and Rehabilitation, CHI St. Joseph Health Assisted Living, CHI St. Joseph Health Rehabilitation Center, and CHI St. Joseph Health Medical Group.

CHI St. Joseph Health affiliated entities, and physician clinics operated by CHI St. Joseph Health participate in an OHCA to manage their joint operating activities similar to the CHI OHCA. The CHI St. Joseph Health OHCA may use and disclose your health information to provide treatment, payment, or health care operations for the affiliated members and includes activities such as integrated information system management, health information exchange, financial and billing services, insurance, quality improvement, and risk management activities.

HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION

For Treatment. We will use your health information to provide you with health care treatment and to coordinate or manage services with other health care providers, including third parties. We may disclose all or any portion of your health information to your attending physician, consulting physician(s), nurses, technicians, health profession students, or other facility or health care personnel who have a legitimate need for such information in order to take care of you. Different departments of the facility will share your health information in order to coordinate the health care services you need, such as prescriptions, lab work and X-rays. We may disclose your health information to family members or friends, guardians or personal representatives who are involved with your health care. We may also use and disclose your health information to contact you for appointment reminders and to provide you with information about possible treatment options or alternatives and other health-related benefits and services. We also may disclose your health information to people outside the facility who may be involved in your health care after you leave the facility, such as other physicians involved in your care, specialty hospitals, skilled nursing care facilities, and other healthcare-related services. We may use and disclose your health information to prescription networks to obtain your prescription benefits from payers, to obtain your medication history from different health care providers in the community such as pharmacies, and to send your prescriptions electronically to your pharmacy.

For Payment. We will use and disclose your health information for activities that are necessary to receive payment for our services, such as determining insurance coverage, billing, payment and collection, claims management, and medical data processing. For example, we may tell your health plan about a treatment you are planning in order to receive approval or to determine whether your plan will pay for the proposed treatment. We may disclose your health information to other health care providers so they can receive payment for health care services that they provided to you, such as your personal physician, and other physicians involved in your health care such as an anesthesiologist, pathologist, radiologist, or emergency physician, and ambulance services. We may also give information to other third parties or individuals who are responsible for payment for your health care, such as the named insured under the health policy who will receive an explanation of benefits (EOB) for all beneficiaries who are covered under the insured's plan.

For Health Care Operations. We may use and disclose your health information for routine facility operations, such as business planning and development, quality review of services provided, internal auditing, accreditation, certification, licensing or credentialing activities (including the licensing or credentialing activities of health care professionals), medical research and education for staff and students, assessing your satisfaction with our services, and to other healthcare entities that have a relationship with you and need the information for operational purposes. We may use and disclose your health information to the external agencies responsible for oversight of health care activities such as The Joint Commission, external quality assurance and peer review organizations, and credentialing organizations. We may also disclose health information to business associates we have contracted with to perform services for or on our behalf such as patient satisfaction survey organizations. We may also disclose your health information to medical device manufacturers or pharmaceutical companies in order for those companies to carry out their legal obligations to state and federal agencies.

CHI Health Information Exchange. CHI St. Joseph Health, as a member of the CHI OHCA, participates in the CHI Health Information Exchange (HIE). Your health information is maintained electronically and healthcare providers, employed, under contract, or otherwise associated with CHI St. Joseph Health and the CHI OHCA members may access, use, and disclose your health information for treatment, payment, and healthcare operations.

Health Information Exchange. CHI St. Joseph Health participates in a secured electronic health information exchange with other affiliated health care entities. As permitted by law, your health information may be shared through this exchange in order to provide faster access, better coordination of care and assist healthcare providers, health payment plans, and public health officials in making more informed decisions.

To opt-out of this health information exchange, please contact the treating hospital based facility's Patient Access Services (PAS). For CHI St. Joseph Health you may write to Patient Access Services at 2801 Franciscan Drive, Bryan, TX 77802 and request an opt-out form or call (979) 776-2908.

With respect to non-hospital based facilities such as physician practices and clinics, please contact the facility directly as you must submit the opt-out request directly to the facility. For more information about opting out you may contact the Corporate Responsibility and Privacy Office at (979) 776-5316 or write to the Corporate Responsibility and Privacy Office at 2801 Franciscan Drive, Bryan, TX 77802.

Facility Directory. The facility directory is available so that your family, friends, and clergy can visit you and generally know how you are doing. We may include your name, location in the facility, your general condition (for example, fair or stable), and your religious affiliation in the facility directory. The directory information, except for your religious affiliation, may be released to people who ask for you by name. Your name and religious affiliation may be given to a member of the clergy such as a priest or rabbi, even if they don't ask for you by name. You must directly notify the individual CHI St. Joseph Health facility's admissions or patient access services department verbally or in writing if you do not want us to release information about you in the facility directory. If you do not want information released in the facility directory, we cannot tell members of the public such as flower or other delivery services or friends and family that you are here or about your general condition.

Future Communications. We may provide communications to you with newsletters or other means regarding treatment options, health related information, disease management programs, wellness programs, or other community based initiatives or activities in which our facility is participating.

Fundraising Activities. We may use your health information, or disclose your health information to a foundation related to us for CHI St. Joseph Health's fundraising efforts. These funds would be used to expand and improve services and programs we provide to the community. We would only release information such as your name, address, other contact information, age, gender, date of birth, health insurance status, dates you received treatment or services from us, the department of service and the outcome of those services.

We do not condition treatment or payment for services on an individuals' participation in fundraising. You have a right to opt out of receiving such communications. To opt out of these communications, please call (979) 774-4087 for assistance or write to CHI St. Joseph Health Foundation at 2801 Franciscan Drive, Bryan, TX 77802.

Research. We may use and disclose your health information to researchers either when you authorize the use and disclosure of your health information, or an Institutional Review Board and/or Privacy Board approves an authorization waiver for the use and disclosure of your health information for a research study. A waiver may allow a researcher to use or disclose your health information to prepare for research, to screen and identify participants for inclusion in a research study, or to conduct research on a decedent's information.

Organ and Tissue Donation. If you are an organ donor, we may release your health information to organizations that handle organ procurement and transplantation or to an organ donation bank as necessary to facilitate organ or tissue donation and transplantation.

USES AND DISCLOSURES THAT ARE REQUIRED OR PERMITTED BY LAW

Subject to requirements of federal, state and local laws, we are either required or permitted to report your health information for various purposes. Some of these reporting requirements and permissions include:

Public Health Activities. We may disclose your health information to public health officials for activities such as for the prevention or control of communicable disease, bioterrorism, injury, or disability; to report births and deaths; to report suspected child, elder, or spouse abuse or neglect; to report reactions to medications or

problems with medical products; to report information to the federal Centers for Disease Control or to authorized national or state cancer registries for their data aggregation.

Disaster Relief Efforts. We may disclose your health information to an entity assisting in a disaster relief effort, such as the American Red Cross, so that your family can be notified about your condition and location.

Health Oversight Activities. We may disclose your health information to a health oversight agency for activities authorized by law. Such agencies include federal Centers for Medicare and Medicaid Services, and state health professional oversight agencies or boards such as state medical or nursing boards. These oversight activities may include audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor activities such as health care treatment and spending, government programs, and compliance with civil rights laws.

Judicial or Administrative Proceeding. We may disclose your health information in response to a legal court or administrative order, a subpoena, discovery request, civil or criminal proceedings, or other lawful process.

Law Enforcement. We may release your health information if asked to do so by a law enforcement official or if we have a legal obligation to notify the appropriate law enforcement or other agencies:

- In response to a court order, subpoena, warrant, summons or similar legal process;
- Regarding a victim or death of a victim of a crime in limited circumstances;
- In emergency circumstances to report a crime, the location or victims of a crime, or the identity, description or location of a person who is alleged to have committed a crime, including crimes that may occur at our facility, such as theft, drug diversion, or attempts to obtain drugs illegally.

Coroners, Medical Examiners and Funeral Directors. We may release health information to a coroner or a medical examiner. This may be necessary to identify a person who died or to determine the cause of death. We may release health information to help a funeral director to carry out his/her duties.

Workers' Compensation. We may release your health information for workers' compensation benefits or similar programs that provide benefits for work-related injuries or illnesses if you tell us that workers' compensation is the payer for your visit(s). Your employer or their workers' compensation carrier may request the entire medical record pertinent to your workers' compensation claim. This medical record may include details regarding your health history, current medications you are taking, and treatments.

To Avert a Serious Threat to Health or Safety. We may disclose your health information when necessary to prevent a serious threat to your health and safety or the health and safety of another person or the public.

National Security. We may disclose your health information to federal official(s) for national security activities and for the protection of the President and other Heads of State.

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.

Inmates. If you are an inmate of a correctional institution or in the custody of a law enforcement official, we may release your health information to the institution or law enforcement official. This release would be necessary for the institution to provide you with health care, to protect your health and safety or the health and safety of others, or for the safety and security of the correctional institution.

OTHER USES AND DISCLOSURES OF YOUR HEALTH INFORMATION

Other uses and disclosures of your health information not covered by this notice or the laws that apply to CHI St. Joseph Health will be made only with your written authorization. If you provide us with authorization to use or disclose your health information, you may revoke that authorization in writing at any time. When we receive your written revocation we will no longer use or disclose your health information for the purpose of that authorization. However, we are unable to retrieve any disclosures already made based on your prior authorization.

CHI St. Joseph Health will obtain your authorization to use and disclose your health information for these specific purposes when required by law and regulation:

Marketing

Marketing is a communication about a product or service that you may be interested in purchasing. If CHI St. Joseph Health receives payment from a third party in order for CHI St. Joseph Health to promote the product or service to you, then CHI St. Joseph Health is required to obtain your written authorization before we can use or disclose your health information. CHI St. Joseph Health is not required to obtain your authorization to discuss with you about CHI St. Joseph Health's health care treatment options, health-related products,, case management or care coordination, or to direct or recommend alternative treatments, therapies, providers, or settings of care, providing face to face discussions and offering samples or promotional gifts of nominal value.

You have the right to revoke your marketing authorization and CHI St. Joseph Health will honor the revocation. To opt out of these communications, please call (979) 776-2458 for assistance or write to the Marketing and Communications Department at 2801 Franciscan Drive, Bryan, TX 77802.

Psychotherapy notes

Psychotherapy notes are notes by a mental health professional that document or analyze the contents of a conversation during a private counseling session or a group, joint, or family counseling session. If psychotherapy notes are maintained separate from the rest of your health information they may not be used or disclosed without your written authorization, except as may be required by law.

Sensitive Medical Information

We may obtain a separate authorization from you, when required by specific state and federal laws, to use or disclose sensitive medical information, such as psychiatric, substance abuse, infectious disease, or genetic testing information.

Sale of Health Information

CHI St. Joseph Health will obtain your authorization for any disclosure of your health information which CHI St. Joseph Health directly or indirectly receives remuneration in exchange for the health information.

THIS NOTICE DOES NOT APPLY TO THE FOLLOWING HEALTH RELATED ACTIVITES

Some activities of CHI St. Joseph Health may not be covered by this notice. If you seek services at wellness or health fairs, for occupational health services, employee health related services, or direct access lab services this notice and its components do not apply.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

You have the following rights regarding your health information:

Right to Inspect and Copy. You have the right to inspect your health information and receive a copy of medical, billing, or other records that may be used to make decisions about your care. The right to inspect and receive a copy may not apply to psychotherapy notes that are maintained separately from your health information.

Your request to inspect and receive a copy of your health information must be submitted in writing. We may charge a fee for document requests to cover the costs of copying, mailing, or other supplies**.** You have the right to request your health information in electronic format. CHI St. Joseph Health will provide your health information in the form and format you request, if feasible, or in a mutually agreeable form and format.

In limited circumstances we may deny your request to inspect or receive a copy of your health information. If we deny your request we will notify you of the reason. If you are denied access to your health information, you may request that the denial be reviewed. A licensed health care professional chosen by CHI St. Joseph Health will review your request and the denial. The person who conducts the review will not be the same person who denied your request. We will comply with the outcome of the review.

Right to Amend. You have the right to request an amendment to your health information that you believe is incorrect or incomplete. Submit your request in writing, including your reason for the amendment, using our "Request for Amendment to PHI" form and send to the following:

For all CHI St. Joseph Health facilities, including CHI St. Joseph Health Bellville Hospital, contact our Health Information Management Department at (979) 776-2524 for assistance or you may write to us at 2801 Franciscan Drive, Bryan, Texas 77802. In completing the Request for Amendment to PHI form, list each facility in which your request is applicable.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. We may also deny your request if you ask us to amend information that:

- Was not created by CHI St. Joseph Health unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the medical information kept by or for CHI St. Joseph Health;
- Is not part of the information that you would be permitted to inspect and copy; or
- Is accurate and complete.

Right to an Accounting of Disclosures. We are required to maintain a list of certain disclosures of your health information. However, we are not required to maintain a list of disclosures that we made by acting upon your written authorizations. You have the right to request an accounting of disclosures that are not subject to your written authorization.

Submit your request in writing using our "Request for Accounting of Disclosures of PHI" form and send to the following:

For all CHI St. Joseph Health facilities, including CHI St. Joseph Health Bellville Hospital, contact our Health Information Management Department at (979) 776-2524 for assistance or you may write us at 2801 Franciscan Drive, Bryan, Texas 77802; and for affiliated physician practices and clinics, you must submit these request directly to the facility.

Your request must state a time period, not longer than six years from the date of request. Please also indicate in your request whether you prefer to receive an accounting response in either paper or electronic format. The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request before any costs are incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on how much of your health information we use or disclose for treatment, payment, or health care operations. You also have the right to request a restriction on the disclosure of your health information to someone who is involved in your care or payment for your care, such as a family member or friend.

We are not required to agree to your request. However, if we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

You have the right to request to restrict the disclosure of your information to a health plan regarding a specific health care item or service that you, or someone on your behalf (other than a health plan), has paid for in full. We are required to comply with your request for this specific type of restriction. For example, if you sought counseling services and paid in full for the services rather than submitting the expenses to a health plan, you may request that your health information related to the counseling services not be disclosed to your health plan.

Submit your request in writing or request and submit a "Request for Restrictions to Use or Disclose Protected Health Information" form and send to the following:

For all CHI St. Joseph Health facilities, including CHI St. Joseph Health Bellville Hospital, contact our Health Information Management Department at (979) 776-2524 for assistance or you may write us at 2801 Franciscan Drive, Bryan, Texas 77802; and for affiliated physician practices and clinics, you must submit these request directly to the facility.

You must include: a description of the information that you want to restrict, whether you want to restrict our use or disclosure or both; and to whom you want the restriction to apply.

Right to Request Confidential Communications. You have the right to request that we communicate with you about health care matters in a certain way or at a certain location. Please inform us during the patient registration process if you intend to submit a request. If we are able to accommodate your request, it will be honored at the facility where you are treated and will need to be resubmitted if you visit another facility within CHI St. Joseph Health. For example, you can ask that we only contact you at an alternative location from your home address, such as work, or only contact you by mail instead of by phone. Your request must specify how or where you wish to be contacted. We do not require a reason for the request. We will accommodate all reasonable requests.

Right to Receive Notice of a Privacy Breach. You have the right to receive written notification if CHI St. Joseph Health discovers a breach of unsecured protected health information involving your health information. Breach means the unauthorized acquisition, access, use, or disclosure of protected health information which compromises the security or privacy of the information. The Notice will include a description of the breach, health information involved, steps we have taken to mitigate the breach, and actions that you may need to take in response to the breach.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. If you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. To ask questions about any of these rights, or to obtain a paper copy of this notice, contact the Corporate Responsibility and Privacy Office at (979) 776-5316 or write to 2801 Franciscan Drive, Bryan, Texas 77802 or, you may obtain a copy of this notice at our Web site, www.chistjoseph.org.

CHANGES TO THIS NOTICE

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for health information we already have about you and for any information we may receive in the

future. We will post a copy of the current notice in the facility and on our web site www.chistjoseph.org. The notice will contain the effective date. Upon your initial registration or admittance to the facility for treatment or health care services as an inpatient or outpatient, we will offer you a copy of the notice currently in effect. Whenever the notice is revised, it will be available to you upon request.

COMPLAINTS

You may file a complaint with us or with the Secretary of the Department of Health and Human Services if you believe that we have not complied with our privacy practices.

You may file a complaint with us by contacting the Corporate Responsibility and Privacy Office at (979) 776-5316 for assistance or you may write us at 2801 Franciscan Drive, Bryan, Texas 77802.

We will not take any action against you or change our treatment of you in any way if you file a complaint.

CHI St. Joseph Health
Imagine better health.[SM]

2801 Franciscan Drive
Bryan, TX 77802

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chistjoseph.org

January 1, 2019

Dear Patient,

Thank you for trusting your health care to CHI St. Joseph Health System. Since 1936, our goal has been to provide excellent care to help you maintain the best health possible.

We share this letter with you to inform you of changes being made in our billing policies for the CHI St. Joseph Health hospitals and clinics. Similar to the changes being made at hospitals across the country, CHI St. Joseph Health is taking a more active role in the care delivered in clinic locations outside of the hospital, where most of patients' day to day medical needs are provided.

As a result, CHI St. Joseph Health is converting many of its physician clinics to hospital-based outpatient clinics. Hospital-based outpatient clinics are a way to increase collaboration between hospitals and physicians by emphasizing better coordination and communication between physician offices and hospital and focusing attention to quality and clinical outcomes. Provider-based clinics, such as CHI St. Joseph Health is creating, are required to meet the same stringent level of regulations that hospitals do.

Under our new policies, patients will continue to receive a bill from the doctor, but may also receive a separate bill for some "hospital-based services" provided by CHI St. Joseph Health Hospital. The amount you owe for your care will be determined by the services you receive from the hospital and services you receive from the doctor. For example, laboratory work and x-rays are provided by departments of CHI St. Joseph Health Regional Hospital and will be billed as a hospital-based service - even though they are delivered in an outpatient clinic environment. The professional services fee for care provided by your doctor will be billed as "physician services" by the physician group (such as CHI St. Joseph Health Primary Care).

With these changes, patients may receive two statements from their insurance carrier, one being for hospital-based services and the other for physician services. These statements will show any amount owed for the visit, as determined by your insurance plan's specific benefits.

Estimate of Charges

Medicare requires that we provide you with an estimate of your Part A and Part B coinsurance amounts. These amounts will vary based on the type and number of services received. An estimate of your coinsurance amounts are as follows:

	Part A	Part B
Office Visit	$11-$17	$12-$27
Radiology	$20-$40	$2-$12
Minor Procedure	$10-$50	$5-$25

As your health care provider, CHI St. Joseph Health is committed to offering you the best care possible. We are also committed to helping you understand our financial and billing policies, so if you have questions regarding these billing policy changes, please contact your physician's office directly for more information.

CHI St. Joseph Health
Imagine better health.SM

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BENEFICIARY INFORMATION NOTICE: Your Doctor Is Participating in a Medicare Shared Savings Program Accountable Care Organization

Accountable Care Organizations (ACOs): Providing Better, Coordinated Care for You
Your Doctor is participating in **St. Joseph Health Partners,** a Medicare Shared Savings Program ACO. An ACO is a group of doctors, hospitals, and/or other health care providers working together with Medicare to give you better, more coordinated service and health care. We share important information and resources about your individual needs and preferences.

You Can Still Choose Any Doctor or Hospital

Your Medicare benefits are not changing. ACOs are **not** a Medicare Advantage plan, an HMO plan, or an insurance plan of any kind. You still have the right to use any doctor or hospital that accepts Medicare, at any time. Your doctor may recommend that you see particular doctors or health care providers, but it's always your choice about what doctors and providers you use or hospitals you visit.

Select Your Primary Clinician On MyMedicare.gov As a Medicare beneficiary, you can log in to MyMedicare.gov and select your primary clinician. Your primary clinician is the health care provider that you believe is responsible for coordinating your overall care. Selecting a primary clinician does not affect your benefits or restrict your ability to get care from any doctor or other clinician you choose. Your selection of a primary clinician will remain the same unless you decide to change your designation. To select your primary clinician, log in to your MyMedicare.gov account or call 1-800-MEDICARE (1-800-633-4227). Search for your primary clinician by typing their name into the provider search tool. Then select the "Add as my primary clinician" option under the provider's name.

Having Your Health Information Gives Us a More Complete Picture of Your Health

To help St. Joseph Health Partners give you better, coordinated care, Medicare will share information with us about your care. The information will include things like dates and times you visited a doctor or hospital, your medical conditions, and a list of past and current prescriptions.

This information from other health care providers will give **your doctor** and other health care providers in ACOs a more complete and up-to-date picture of your health. Over time, you may notice that you don't have to fill out as many medical forms that ask for the same information, you don't need to repeat medical tests because your results are shared among your health team, and other benefits because your providers are communicating with one another.

If you choose to let Medicare share your health care information with St. Joseph Health Partners, it may also be shared with other ACOs in which your other doctors or health care providers participate. If you don't want your health care information shared, you can ask Medicare not share it.

Your Privacy is Very Important to Us

Just like Medicare, ACOs must put important safeguards in place to make sure all your health care information is safe. ACOs respect your choice on the use of your health care information for care coordination and quality improvement.

Yes, share my information: If you want Medicare to share information about the health care you received with St. Joseph Health Partners or with other ACOs in which your other doctors or health care providers participate, **there's nothing more you need to do.**

No, please don't share my information: If you do not want Medicare to share your health care information, you **need to** do the following:

- Call 1-800-MEDICARE (1-800-633-4227). Tell the representative that your doctor is part of an ACO and you do not want Medicare to share your health care information. TTY users should call 1-877-486-2048.
- If you change your mind in the future, call 1-800-MEDICARE and tell the representative what you have decided. We can't communicate with Medicare on your behalf. Even if you decline to share your health care information, Medicare will still use your information for some purposes, like assessing the financial and quality of care performance of the providers participating in ACOs. Also, Medicare may share some of your health care information with ACOs when measuring the quality of care given by health care providers participating in those ACOs.

Questions? If you have questions or concerns, call us at 979-774-2101, or we can discuss them next time you're in our office. You can also call 1-800-MEDICARE and tell the representative you're calling to learn more about ACOs, or visit Medicare.gov/acos.html.

Revised September 2017