MR #: _____ **Date:** __ __ / __ __ / __ __ __ __

ACCORDIA HEALTH

Registration Form

Patient Information

Patient's Legal Name: _____
First Middle Initial Last

Former Name: _____ **Nickname:** _____

Birth Sex: Male Female **Social Security Number:** _____- _____- _____ **Date of Birth:** _____/_____/_____

Phone: _____ _____ _____
Home Work Cell

Current Address: _____

City: _____ **State:** _____ **Zip Code**: _____

Email Address: _____

Emergency Contact

Name: _____**Relationship**: _____ **Phone:** _____

Patient Demographics: (circle your response)

Sexual Orientation: Straight Lesbian or Gay Bisexual Something Else Don't Know Choose not to disclose

Gender Identity: Male Female Transgender Male Transgender Female Other Choose not to disclose

Marital Status: Single Married Divorced Widowed Annulled

Race: White Black or African American Other Pacific Islander Native Hawaiian

American Indian or Alaska Native More than one Race Unreported/Refused to Report Race

Ethnicity: Not Hispanic or Latino Declined to specify Hispanic or Latino Unknown Other

Preferred Language: English Lao Vietnamese Other: _____

Homeless status: Not Homeless Homeless Other: _____

Agricultural/Fishing Worker Status: Not a Farm Worker Migrant Worker Seasonal Worker

Language Barrier: Yes No

Public Housing: No Other Public Housing Tenant Based Voucher

Veteran Status: Yes No

Patient Employment:

Employer Name: _____ **Employer Phone**: _____

Yearly Household Income (circle one): $0-$15,000 $15,001-$30,000 $30,001-45,000 $45,001-$60,000 $60,001 or more

Family Size: 1 2 3 4 5 6 7 8 9 10

MR #: _____ **Date:** ☐☐ / ☐☐ / ☐☐☐☐

Guarantor Information (*Information of person financially responsible for patient*)**:**

☐ Check if same as above patient; If not please fill out the following:

Name: _____ Relationship: _____

DOB: _____/_____/_____ SSN: _____- _____- _____ Phone: _____

Current Address: _____

City: _____ State: _____ Zip Code: _____

Email Address: _____

Guarantor Employer Name: _____ Employer Phone: _____

Insurance Information

Primary Insurance Plan Name: _____

Policy ID: _____ Group #: _____

Subscriber Name: _____ Subscriber DOB: _____/_____/_____

Subscriber SSN: _____- _____- _____ Subscriber Relationship to Insured: _____

Secondary Insurance Plan Name (*If applicable*): _____

Policy ID: _____ Group #: _____

Subscriber Name: _____ Subscriber DOB: _____/_____/_____

Subscriber SSN: _____- _____- _____ Subscriber Relationship to Insured: _____

Preferred Pharmacy:

Pharmacy Name: _____

Pharmacy Phone Number: _____

Pharmacy Location: _____

Patient/Legal Guardian Signature: _____ Date: _____

MR#: | | | | | | | EP: | | | Date: | | | – | | | – | | | | |
M M D D Y Y Y Y

ACCORDIA HEALTH

INFORMED CONSENT FOR VERBAL/ EMAIL EXCHANGE OF INFORMATION

I, _____ hereby consent to the verbal/ email exchange of information between
(Print patient name)

Accordia Health and: _____
(Name of person or organization and contact information)

_____
(Name of person or organization and contact information)

_____
(Name of person or organization and contact information)

_____
(Name of person or organization and contact information)

regarding_____
(Information that will be discussed)

For admission of _____ and for the following purpose:
(Date of admission)

☐ Facilitate Evaluation and Treatment
☐ Participate in treatment
☐ Other
Specify: _____

I understand that this consent will expire on _____ (Two years from the signature date) or at the time of my discharge from this program, whichever comes first. I understand that I may revoke this consent at any time. The revocation may be given *verbally or in writing*, and it will not apply to information that was discussed prior to my revocation of this consent.

I have been informed that copies of my medical record can only be released by my signing an authorization giving my permission to do so.

_____ _____
Patient Signature Date

_____ _____
Guardian/ Legal Representative Signature Date

_____ _____
Witness Signature Date

_____ _____
Witness Signature (if appropriate) Date

MR#: EP: Date: M M – D D – Y Y Y Y

Accordia Health
STATEMENT OF UNDERSTANDING

PATIENT NAME: _____

Read Each Statement and Initial to indicate understanding:

_____ Payment Agreement: For and in consideration of services rendered by Accordia, Patient (responsible person) herby agrees to and guarantees payment of all Accordia charges incurred. I understand that if an agency or company is responsible for payment of services, that agency or company will have the right to review the services I receive at Accordia. I also understand that I may be charged a fee or co-payment for services and that it is expected, if I am responsible for the payment of these services, to pay for them as they are received. I further understand I should contact Accordia if there are any changes to my insurance.

_____ Methods of Payment: Our office accepts the following payment methods: Cash, Personal Check, Credit Cards and Money Orders.
There will be a $25.00 NSF charge for all returned checks.

_____ Fee Schedule: I understand that I am responsible for payment for services rendered by Accordia Health, Inc. at its standard rates provided to me on the fee schedule.

_____ Sliding Fee Scale Program: Accordia Health maintains a system in place to determine eligibility for patient discounts adjusted on the basis of the patient's ability to pay. Qualified individuals may apply to participate in the reduced fee program by completing an Application available at the Receptionist desk. Once a patient's ability to pay is determined, the patient is expected to pay for services based on the assigned percent of charges they are deemed able to pay.

_____ Self-Pay: I agree to pay Accordia in full for services rendered.

_____ Co-Payments and Deductibles: All Co-payments and Deductibles are to be paid at the time of service.

_____ Late Shows: If you are 15 minutes late or greater for your appointment, it will be at the discretion of the Provider to see you.

_____ Medicaid: Patient certified that the information given in applying for payment under Title XIX (19) of the Social Security Act is correct. Patient authorizes any holder of medical or other information about Patient to release to the respective State Medicaid Agency or its intermediaries or carries any information needed for this or a related Medical claim. Patient requests that payment of authorized benefits be made on his/her behalf.

_____ Medicare: Patient certified that the information given in applying for payment under Title XVIII (18) of the Social Security Act is correct. Patient authorizes any holder of medical or other information about Patient to release to the Social Security Administration or its intermediaries or carries any information needed for this or a related Medical claim. Patient requests that payment of authorized benefits be made on his/her behalf.

_____ Assignment of Insurance Benefits and Agreement to Pay Any Balance: Patient (responsible party) irrevocably assigns and transfers to Accordia all right, title and interest to medical reimbursement benefits under any and all applicable medical insurance policies covering Patient, for the payment of treatment and medical care being provided. Patient (responsible party) authorizes payment directly to Accordia Health of said medical reimbursement benefits. Patient (responsible party) is responsible for any co-payments, co-insurance, deductibles, and/or other amounts specified by my insurance. In the event the said medical insurance coverage is not sufficient to satisfy the Accordia charge in full, Patient (responsible party) acknowledges that the resulting balance is not covered by this assignment and agrees to be fully responsible for the payment. I understand that my agreement with my insurance carrier is a private one, and that Accordia does not routinely research why my insurance carrier has not paid or why it paid less than anticipated for care.

_____ Patient Rights Statement: I understand that Accordia subscribes to a Patient Rights Statement, which has been made available to me. I have had the opportunity to have the Patient Rights Statement explained to me.

_____ Procedure to Review Records: I have been furnished with a copy of the Procedure to Review my health record and had it explained to me.

_____ Notice of Privacy Practices: I have been furnished a copy of the Notice of Privacy Practices and have had it explained to me. I understand that the information concerning the treatment of _____ will be held in confidence by the Accordia staff unless I give specific written consent for the release of information. In case of emergency Accordia is authorized to request or release that information which is essential to handle the emergency.

Also, Accordia staff will not release any information except as required by law or Court Order under compelling disclosure, or in a situation deemed potentially life-threatening, and in the following instances: Suspected Child Abuse, threats of physical harm to self and/or others, espionage or sabotage.

The confidentiality of your participation may also be protected by federal and state laws and regulations. The violation of federal requirements is a crime, and suspected violations may be reported. Federal regulations do not protect from disclosure of information related to a consumer's commission of a crime against Accordia property or personnel, or reports under state law of suspected child abuse or neglect (See 42 U.S.C. 290 ee 3 for federal laws 42 CFR Part 2 for federal regulations).

_____ Advance Directives: ___ I have a medical advance directive and have provided a copy to Accordia. ___ I do not have a medical advanced directive, and have been provided information by Accordia.

_____ Rehabilitation Act: It is the policy of Accordia, in compliance with Section 504 of the Rehabilitation Act of l973, to afford qualified handicapped persons an opportunity to receive benefits or services that are equal to that offered non-handicapped persons. Any person who feels he/she has not received treatment in accordance with this policy may submit a compliant with the Patient Needs Specialist, Accordia Health, 5750-A Southland Drive., Mobile, Al. 36693.

_____ Health Information Exchange (HIE): Accordia participates in a HIE called Care Quality. I understand that any physician or hospital that participates in the Care Quality HIE either directly or indirectly may request for the purpose of my continuity of care the following limited set of records regarding my care: Allergies, Demographics, Labs, Immunizations Medications, and Problem Lists. You many chose to Opt-Out of allowing your health information to be shared through the Care Quality HIE by requesting an Opt-out form.
All other releases will follow the practices explained in Your Notice of Privacy Practices.

_____
Print Patient's Name | Patient's Signature | Date

_____ _____
Parent/Legal Representative Signature | Date | Witness Signature | Date

_____
Second Witness Signature (required when signed with a mark)

MR #: _____ **Date:** __ __ / __ __ / __ __ __ __

CONSENT FOR TREATMENT AND DISCLOSURE OF HEALTH INFORMATION

PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Treatment: I hereby authorize Accordia to provide me with needed medical treatment and services by the Doctors and Certified Nurse Practitioners (CRNP) of this Primary Medical Care clinic. I understand that treatment and services may include lab tests, screening tests, diagnostic tests and routine exams.

Purpose of Consent for Disclosure: As part of my healthcare, Accordia Health originates and maintains health records describing my health history, symptoms, examinations, test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill,
- A means by which a third- party payer can verify that services billed were actually provided,
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals,
- A basis for Accordia Health to review my health information and consider my potential eligibility for recruitment into various clinical trials.

Notice of Privacy Practices: I have been furnished a copy of the Notice of Privacy Practices and have had it explained to me. I understand that the information concerning the treatment will be held in confidence by the Accordia staff unless I give specific written consent for the release of information. In case of emergency Accordia is authorized to request or release that information which is essential to handle the emergency. Also, Accordia staff will not release any information except as required by law or Court Order under compelling disclosure, or in a situation deemed potentially life-threatening, and in the following instances: Suspected Child Abuse, threats of physical harm to self and/or others, espionage or sabotage. The confidentiality of your participation may also be protected by federal and state laws and regulations. The violation of federal requirements is a crime, and suspected violations may be reported. Federal regulations do not protect from disclosure of information related to a Patient's commission of a crime against Accordia property or personnel, or reports under state law of suspected child abuse or neglect (See 42 U.S.C. 290 ee 3 for federal laws 42 CFR Part 2 for federal regulations).

E-mail Communications: By signing below and providing the relevant contact information I consent to allow Accordia Health to communicate with me via e-mail. I understand that communications via e-mail may not be secure and my personal health information could be intercepted and breached. I agree that the company will not be liable for the protection of my health information that I have requested be communicated via e-mail.
E-mail address: _____
Cell phone number including area code: _____

Consent for Residents, Interns, and Medical and Nursing Students to Participate in my Treatment: I am aware that, residents, interns, medical and nursing students, could be present for educational purposes. I understand that in the educational process they may observe or participate in my or my child's treatment and/or review my or my child's medical record.

Consent to Photographs: I consent to have my photograph taken by the staff at Accordia as part of the admission process. I understand that this photograph will be placed in my individual medical record in keeping with this facility's system of Patient identification, and will be used for identification purposes only when necessary during the course of my treatment.

MR #: | | **Date:** | | | / | | | / | | | | |

Right to Revoke: You have the right to revoke this Consent at any time by giving written notice of my revocation submitted to Accordia Health. Please understand that revocation of this Consent will *not* affect any action we took prior to this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I, _____, have had full opportunity to read and consider the Consents of this consent form and your Notice of Privacy Practices. I understand that, by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

_____ _____/_____/_____
Signature of Patient Date

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

_____ _____/_____/_____
Signature of Personal Representative Date

Relationship to Patient _____

MR #: _____ **Date:** __ __ / __ __ / __ __ __ __

NEW PATIENT HEALTH HISTORY QUESTIONNAIRE

All information contained in this questionnaire is strictly confidential and will become a part of your medical record.

Name: _____
Last First MI

Sex: ☐ Male ☐ Female Date of Birth: _____/_____/_____ Age: _____

What is the main reason for your visit today? _____

Is it related to an accident? ☐ No ☐ Yes, it is ☐ Work Injury ☐ Motor vehicle accident ☐ Other:_____

ALLERGIES: Do you have any drug/food allergies or intolerances? ☐ No ☐ Yes; please describe below

_____

_____

MEDICATIONS: Please list all medications that you are taking, including non-prescription medications (Advil, Aleve, Motrin, Tylenol, etc.), vitamins, and supplements.

Name of drug	Dose (strength and times taken per day)	How long have you taken this?

IMMUNIZATIONS: Please enter the year of any vaccinations you have had.

☐ Hepatitis A _____ ☐ Flu Shot _____ ☐ Meningitis _____ ☐ MMR _____

☐ Hepatitis B _____ ☐ Pneumonia _____ ☐ Shingles _____ ☐ Tetanus _____

☐ HPV _____ ☐ Chicken Pox (shot or illness) _____ ☐ Other: _____

Have you had a colonoscopy/sigmoidoscopy?

☐ No ☐ Yes; when and where was it performed? _____

WOMEN ONLY:

Number of pregnancies: _____ Number of children: _____ Number of miscarriages: _____ Number of abortions: _____

Last pap smear (date and location): _____ Have you had an abnormal pap smear? ☐ Yes ☐No

Last period: _____ Age at first period: _____ Age at menopause: _____

Last bone density scan (date and location): _____

Last mammogram (date and location): _____

MEN ONLY:

Last prostate exam (date and location): _____

Last PSA (prostate blood test) (date and location): _____

HOSPITALIZATIONS/SURGERIES: Please list the hospitalizations and/or surgeries and the reason:

Year	Reason for surgery/hospitalization	Hospital

MR #: _____ **Date:** __ __ / __ __ / __ __ __ __

PAST MEDICAL HISTORY: Do you now or have you had any of the following?

☐ Alcohol/Drug abuse	☐ Allergy (hay fever)	☐ Anemia
☐ Arthritis	☐ Asthma	☐ Blood clot
☐ Bruising	☐ Cancer (type _____)	☐ Cataracts
☐ Depression/ Anxiety	☐ Diabetes	☐ Difficulty breathing
☐ Dizziness	☐ Eczema	☐ Emphysema
☐ Eye pain	☐ Fainting or loss of consciousness	☐ Fatigue
☐ Fractures (broken bones)	☐ Gallbladder disease	☐ Glaucoma
☐ Gout	☐ Hair loss	☐ Hearing loss
☐ Heartburn/ Reflux	☐ Heart attack (when _____)	☐ Heart problems
☐ Hepatitis	☐ High blood pressure (hypertension)	☐ High cholesterol
☐ HIV/AIDS	☐ Hyperthyroidism	☐ Hypothyroidism
☐ Jaw pain/TMJ	☐ Kidney disease/ problems	☐ Leg pain/swelling
☐ Liver disease/ problems	☐ Memory loss	☐ Migraine headaches
☐ Muscle weakness	☐ Nausea	☐ Night sweats/hot flashes
☐ Osteoporosis	☐ Pneumonia	☐ Prostate disease/ problems
☐ Psoriasis	☐ Seizure/Epilepsy	☐ Skin conditions/rashes
☐ Sleep apnea	☐ Stomach ulcer	☐ Stroke (when _____)
☐ Urination increase/decrease	☐ Vision problems	☐ Vomiting, persistent

☐ Other: _____

MEDICAL PROVIDERS: Please list the names of other healthcare providers and the problems for which they are treating you.

_____

_____

_____

FAMILY HISTORY:

	Living?	Age (current or at death)	Current medical problems or cause of death
Father:	☐ Yes ☐ No		
Mother:	☐ Yes ☐ No		
Brothers:	☐ Yes ☐ No		
Sisters:	☐ Yes ☐ No		
Daughters:	☐ Yes ☐ No		
Sons:	☐ Yes ☐ No		

SOCIAL HISTORY:

Do you exercise regularly? ☐No ☐ Yes; how often? _____

Do you drink alcohol? ☐No ☐ Yes If yes, how many drinks per day? _____ How many per week? _____

Do you currently or have you ever smoked? ☐No ☐ Yes If yes, how much? _____ For how long? _____

Do you currently or have you ever used smokeless tobacco? ☐No ☐ Yes If yes, how much? _____ For how long? _____

Have you used drugs other than those required for medical reasons? ☐No ☐ Yes

How many times in the past year have you used an illegal drug or used a prescription medication for non-medical reasons? _____

Are you currently or have you ever been sexually active? ☐No ☐ Yes Are your sexual partners: ☐ Male ☐ Female ☐ Both

Thank you for taking the time to complete this form.

_____ _____

Signature of Patient or Legal Representative *Date*

Accordia Health
NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We have a legal duty to safeguard your (PHI) Protected Health Information. This PHI includes information that can be used to identify you that we have created or reviewed about your past, present or future health conditions. It contains what healthcare we have provided to you, or the payment history on healthcare related accounts. We must provide you with notice about our privacy practices and explain how, when and why we use and disclose your PHI.

We will not use or disclose your health information without your authorization, except as described in this notice or otherwise required by law. We are legally required to follow the privacy practices that are described in this notice.

CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE RECORDS:

The confidentiality of alcohol and drug abuse records maintained by this organization is protected by federal law and regulations. Generally, the program may not communicate to a person outside the program that you attend the program, or disclose any information identifying you as an alcohol or drug abuser unless one of the following conditions is met:

* you consent to it in writing
* the disclosure is allowed by a court order
* the disclosure is made to medical personnel in a medical emergency or to qualified personnel for program evaluation

Violations of federal laws and regulations by a program are a crime. Suspected violations may be reported to the appropriate authorities in accordance with federal regulations.

Federal laws and regulations do not protect any information about a crime committed by you either at the program or against any person(s) who works for the program or about any threat to commit such a crime.

Federal laws and regulations do not protect any information about suspected child abuse or neglect from being reported under state law to appropriate state or local authorities.

YOUR HEALTH INFORMATION RIGHTS:

Although your medical record is the physical property of Accordia Health, the information belongs to you. You have the right to:

* request in writing a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522
* request in writing to obtain a paper copy of your health record as provided for in 45 CFR 164.524
* request in writing to amend your health record as provided in 45 CFR 164.526
* obtain a paper copy of the notice of information practices upon request
* request in writing to obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528
* request in writing communication of your health information by alternative (other) means or at other locations
* revoke in writing your authorization to use and disclose health information except to the extent that action has already been taken
* obtain notice following any breach of your unsecured protected health information as provided in 45 CFR 164.520(b)(1)(v)(A)

OUR RESPONSIBILITIES:

Accordia Health is required to:

* maintain the privacy of your health information
* provide you with notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
* abide by the terms of this notice
* notify you if we are unable to agree to a requested restriction
* accommodate reasonable requests you may have to communicate health information by other means or at other locations
* train our personnel concerning privacy and confidentiality; implement a sanction policy to discipline those who breach privacy or confidentiality of our policy

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our Information practices change; the revised notice will be available through your clinician and in the lobby of the facility.

We will not use or disclose your health information without your authorization, except as described in this notice.

FOR MORE INFORMATION OR TO REPORT A PROBLEM:

If you have questions and would like additional information, you may contact the Patient Relations Specialist at 251-450-4303.
If you believe your privacy rights have been violated you can file a complaint with the Patient Relations Specialist at Accordia Health or with the Secretary of Health and Human Services. There will be no retaliation for filing a complaint.

Your written statement to Accordia Health and/or the Office of Civil Rights must include your name; address; telephone number; your signature; how, why, and when you believe you were discriminated against; name and address of institution or agency you believe discriminated against you; and any other relevant information.

You may submit in writing a request for review of any discrepancy or complaint under HIPAA to any of the following:

Director
Office of Civil Rights
U.S. Department of Health & Human Service
61 Forsyth St., SW – Suite 31370
Atlanta, GA 30323
(404) 562-7858 or 562-7884

Patient Relations Specialist
Accordia Health
5750-B Southland Drive
Mobile, AL 36693
(251) 450-4303

EXAMPLES OF DISCLOSURES FOR TREATMENT, PAYMENT AND HEALTH OPERATIONS:

We will use your health information for treatment (fox example):
Information obtained by a, doctor, nurse or other mental health professional will be recorded in your record and used to determine the course of treatment that will work best for you. Any service provided to you will be documented in the record.

We will use your health information for payment (for example):
A bill may be sent to you or a third party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis. You may request restrictions on such uses only if the request relates to services paid of out-of-pocket and the request is for nondisclosure to a health plan related solely to such services as provided in 45 CFR164.520(v)(1)(iv)(a) and 164.522(a)(1)(vi)

We will use your health information for regular health operations (for example):
Members of the medical staff, the risk or quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it.

Business Associates:
We provide some services through contracts with business associates. (Example: certain diagnostic tests).

Directory:
We do not have a directory that provides any information concerning your treatment here.

Notification:
We will not disclose any information to anyone about you without your written consent/authorization. Examples of uses or disclosures requiring your authorization include most disclosures of psychotherapy notes as provided in 45 CFR 164.520(b)(1)(ii)(E)

Comm*unication with Family:*
Only with your written authorization/consent will we disclose to a family member, another relative, a close friend, or any other person that you identify; health information relevant to that person's involvement in your care or payment related to your care.

Research:
We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Funeral Directors:
We may disclose health information to funeral directors consistent with applicable law to enable them to carry out their duties.

Marketing/continuity of care:
We may contact you to provide appointment reminders or information about treatment alternatives that may be of interest to you.

Fund raising:
We will not contact you concerning any fund raising activities.

Food and Drug Administration (FDA):
We may disclose to the FDA health information relative to adverse effects/events with respect to food, drugs, supplements, product or product defects, or postmarking surveillance information to enable product recalls, repairs, or replacements.

Workers Compensation:
We may disclose information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public Health:
We may disclose your health information as required by law.

Correctional institution:
If you are an inmate of a correctional institution, we may disclose to the institution health information necessary for your health and the health and safety of other individuals.

Law Enforcement:
We may disclose your health information for law enforcement purposes as required by law or in response to a court order.

Health Oversight Agencies & Public Health Authorities:
By Federal law provisions your health information may be released provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

WE RESERVE THE RIGHT TO CHANGE OUR PRACTICES AND TO MAKE THE NEW PROVISIONS EFFECTIVE FOR ALL INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (MEDICAL RECORDS) THAT WE MAINTAIN. IF WE CHANGE OUR INFORMATION PRACTICES, WE WILL HAVE THE REVISED NOTICE AVAILABLE IN THE LOBBYOF THE FACILITY.

Patient Rights

As a patient of Accordia Health Primary Care, you have the following rights:

- To be treated with respect, consideration, dignity and to receive high quality healthcare.
- To not be discriminated against in the delivery of healthcare services.
- To be assured of confidential treatment and to authorize the release of identifiable healthcare and other personal information.
- To review and receive copies of your medical records and/or request that your records be amended.
- To choose your healthcare provider.
- To be informed of your medical condition, treatment plan, and expected outcome.
- To receive accurate, easily understood information and to request assistance or be represented by parents, guardians, family members, or others in making informed healthcare decisions.
- To refuse treatment and refuse to participate in research.
- To be informed of the names, functions, and credentials of all persons providing service to you and to receive the names and telephone numbers of management.
- To be informed of available services, hours of service, and after hour coverage.
- To have a fair and efficient process for voicing grievances.

Patient Responsibilities

As a patient of Accordia Health Primary Care, you have the following responsibilities:

- To give truthful and accurate information about your health and past medical treatment.
- To ensure that you fully understand and follow the treatment plan prescribed by your healthcare provider.
- To inform your healthcare provider of any changes in your condition or of any adverse reactions to the treatment plan.
- To keep appointments and inform the center in advance when you are unable to keep an appointment.
- To pay for services rendered in accordance with the fee policy and to provide truthful and accurate financial and/or insurance information to allow for appropriate billing.
- To become informed of and to follow health center rules and regulations concerning patient care and conduct.

Procedure for Review of Records

Any consumer or legal representative of a consumer may request an opportunity to review his/her records to obtain information from his/her records at Accordia Health. Such a request must be submitted in writing on a facility provided *Release of Authorization to Disclose Protected Health Information* form.

Upon receipt of this request, the Health Information Department shall forward the consumer's request and medical record to the clinician for determination if release of information would be detrimental to the consumer.

If after review the clinician determines the information may be released, the requested information will be copied and released to the consumer.

The copying fee for such requested records is:

On disc: $6.50 disk fee
On paper: $5.00 labor fee, $1.00 per page for the first 25 pages, $0.50 per page thereafter
$15.00 Certification fee if requested

Requests for Release of Health Information not completed and witnessed at one of our facilities require a notarized validation of identity of the requestor.

Appeal Process

Step 1: You may report any complaint/grievance to any employee of Accordia. All complaints received will be reported to the Consumer Needs Specialist. You will receive a response with possible solutions to your complaint within 10 working days from the Consumer Needs Specialist.

Step 2: If you are not satisfied with the solution you may request that your complaint be reviewed by the Consumer Needs Committee. You will receive a response with a possible solution from the Consumer Needs Committee within 10 working days.

Step 3: If you are not satisfied with the solution offered by the Consumer Needs Committee you may request that your complaint be reviewed by the CEO of Accordia Health. You will receive a response from the CEO within 30 days.

At any time you may contact the following agencies regarding your complaint/grievance:

Department of Mental Health – Mental Retardation Office of Advocacy Services
1-800-367-0955

Alabama Disabilities Advocacy Program
1-800-826-1675

Consumer Needs Specialist
(251) 450-4303

Department of Human Resources
(251) 450-9100 (Children) or (251) 450-1800 (Adult)

You may contact the Joint Commission's Office of Quality Monitoring to report any concerns or register complaints about ACCORDIA by either calling 1-800-994-6610 or e-mailing complaint@jointcommission.org.

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NB-212