OLOL Head and Neck Center

4950 Essen Lane, Suite 400 – Baton Rouge, Louisiana 70809
Phone: (225) 765-1765 Fax: (225) 765-1783

This is a reminder that you have an appointment with OLOL Head and Neck Center. Your appointment is scheduled with:

Dr. ________________________________

On ____________________________ At ___________________

Enclosed is your New Patient Packet. Please DO NOT MAIL the completed paperwork to our office. Instead, BRING THIS PAPERWORK, your driver's license/identification, and insurance card with you to the office visit, and arrive 15 minutes before your scheduled appointment.

Also, please bring current medications in the bottles or packages to ensure accurate documentation. Please obtain the disc/films and reports of any recent studies done (MRI, CT, Swallow Study, Sleep Study, etc.), and bring them with you on the day of your appointment.

Thank you.

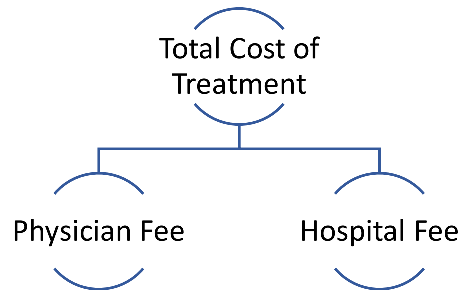
Patient Name: ________________________________
Patient DOB: ________________________________

Assumption Community Hospital
Heart Hospital of Lafayette
Our Lady of Angels Hospital
Our Lady of Lourdes Regional Medical Center
Our Lady of the Lake Ascension
Our Lady of the Lake Regional Medical Center
St. Dominic Jackson Memorial Hospital
St. Francis Regional Medical Center
Women's and Children's Hospital

FMOLHS NOTIFICATION OF OUTPATIENT SERVICE CHARGES

This clinic is an outpatient department of the hospital. It is important that each patient understands that this clinic is not just a physician practice, this clinic is an extension of the hospital's outpatient services.

For each visit with your physician at this clinic, you will receive two bills for services provided. One bill will come from the physician group and one will come from the hospital. These bills are not duplicate charges, but a separation of the facility and the physician or provider's fees.



Billing

The physician's charge includes the physician's time and services for the interpretation of testing performed in the clinic. In addition, the physician may refer you for other services operated by the hospital, such as laboratory and X-ray. The bill for additional services performed will be billed through the hospital.

Because your physician's clinic facility is owned by the hospital, the hospital bills a "facility charge" for each visit to the outpatient clinic. You will receive a bill from the hospital for the facility charge. This fee covers the cost of the clinic space, supplies and other items.

The hospital and the physician will both bill your insurance provided your insurance information is current. Please remember to bring your insurance card to every visit for verification. In addition, all charges must be submitted to your insurance as outpatient hospital services and not as an office visit.

Co-Pays/Deductibles

If your insurance plan requires a co-payment or a deductible for outpatient hospital visits,

Patient Name: ________________________________
Patient DOB: ________________________________

please be prepared to pay at the time of your visit. Please be advised that if your insurance plan has a deductible on outpatient hospital services, that deductible would apply to your charges for services incurred in this clinic.

If you have any questions regarding charges or you need an itemized statement, you may call the Franciscan Billing Office at (225) 765-8872.

Franciscan Missionaries of Our Lady Health System is committed to providing financial assistance to those who have healthcare needs and are uninsured or underinsured. The Franciscan Missionaries of Our Lady financial assistance program is offered to help ensure your financial condition or state is not preventing you from receiving the care you need. Please inquire if you believe you may be eligible and would like to apply for financial assistance.

Patient Name (print):

____

Patient Signature:

____

Date: _____________________________________ **Time:** __________________________

Legal Guardian Name (print):

____

Legal Guardian Signature:

____

Date: __________________________________ **Time:** ______________________________

Patient Name: ______________________________
Patient DOB: ______________________________

Assumption Community Hospital
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Women's and Children's Hospital

PATIENT INFORMATION SHEET

MRN (Epic): ______________________

Name: ____ **SSN:** *(please provide to registrar)*
Last *First* *Middle*

Sex: M F **Date of Birth:** ____________ **Other Known Name(s):** __________________________

Mailing Address: ____
Street *City* *State* *Zip*

Preferred Contact Number (circle one): Home Work Cell

Home Phone: _______________ **Work Phone:** _________________ **Cell Phone:** ________________

Email Address: ____

Preferred Language (circle one): English Spanish Other: ___________________

Please circle one option for each of the categories below.

Marital Status	**Ethnicity**	**Race**
Married	Hispanic or Latino	American Indian/Alaskan Native
Divorced	Non-Hispanic or Non-Latino	Asian
Legally Separated	Unknown	Black/African American
Single	Other	Native Hawaiian/Pacific Islander
Widowed		White/Caucasian
Significant Other/Partner		Unknown
		Other

Primary Care Physician (PCP): ____

Referring MD (if different than PCP): ____

Emergency Contact: ____

Phone: __________________________________ **Relationship to Patient:** _____________________

Patient Name: ___________________________

Patient DOB: ___________________________

RESPONSIBLE PARTY INFORMATION

(if different from patient)

Primary Guardian: ___________________________
Last First MI

Relationship to Patient: ______________________

Mailing Address: ___________________________

City/State/Zip: ___________________________

Parish/County: ___________________________

Home Phone: ___________________________

Cell Phone: ___________________________

Date of Birth: ___________________________

SSN: ___________________________

Employment Status (circle one):

Active Military Duty
Disabled
Full-Time
Part-Time
Part-Time Student
Retired
Self-Employed
Unemployed
Unknown

Secondary Guardian: ___________________________
Last First MI

Relationship to Patient: ______________________

Mailing Address: ___________________________

City/State/Zip: ___________________________

Parish/County: ___________________________

Home Phone: ___________________________

Cell Phone: ___________________________

Date of Birth: ___________________________

SSN: ___________________________

Employment Status (circle one):

Active Military Duty
Disabled
Full-Time
Part-Time
Part-Time Student
Retired
Self-Employed
Unemployed
Unknown

INSURANCE POLICY HOLDER INFORMATION

(if different from patient and responsible party)

Name: ____ **SSN:** ______________________
Last First Middle

Sex: M F **Date of Birth:** _____________ **Other Known Name(s):** ___________________________

Relationship to Patient: ____

Mailing Address: ____
Street City State Zip

Parish/County: ____

Home Phone: ________________ **Work Phone:** __________________ **Cell Phone:** _________________

Employment Status (circle one):

Patient Name: ________________________________
Patient DOB: ________________________________

Active Military Duty	Part-Time	Self-Employed
Disabled	Part-Time Student	Unemployed
Full-Time	Retired	Unknown

INSURANCE INFORMATION

Primary Coverage	Secondary Coverage
Insurance Company: ________________________	**Insurance Company:** _________________________
Insurance Address: _________________________	**Insurance Address:** __________________________
City/State/Zip: _____________________________	**City/State/Zip:** _____________________________
Phone: ___________________________________	**Phone:** ____________________________________
Insurance ID Number: _______________________	**Insurance ID Number:** ________________________
Effective Date: _____________________________	**Effective Date:** ______________________________
Group Number: ____________________________	**Group Number:** _____________________________
Covered Through (circle one):	**Covered Through (circle one):**
Current Employer Retirement COBRA/Continuation of Benefits	Current Employer Retirement COBRA/Continuation of Benefits
Employer: _________________________________	**Employer:** _________________________________
Employer Address: _________________________	**Employer Address:** __________________________
City/State/Zip: ____________________________	**City/State/Zip:** _____________________________
Employer Phone: ___________________________	**Employer Phone:** ____________________________
Employee Size (circle one): 1-19 20-99 100+	**Employee Size (circle one):** 1-19 20-99 100+

SIGNATURE

By initialing next to each item below, then signing my name at the bottom of this form, I agree to the following:

______ Pre-certification or prior approval may be required by your health plan before certain procedures, tests, or surgeries are performed. We will assist you in the pre-certification process by contacting your insurance company on your behalf. However, it is your responsibility to confirm that you have been granted approval or certification before your appointment or you will be responsible for any charges insurance has not granted prior approval.

Patient Name: ________________________________
Patient DOB: ________________________________

______ Your appointment time is reserved for you and your provider. In order for our providers to stay on schedule and spend quality time with you, we ask that you arrive promptly. Although we do realize that emergencies do occur, we expect you to keep all of your appointments. If you need to reschedule an appointment, we require a 24-hour notice. This is a courtesy not only to the providers but to other patients who may need to schedule their medical care. In an instance of repeated noncompliance with your scheduled visits, we reserve the right to discontinue care.

______ Your physician at his/her discretion and judgment, may discontinue treatment of a patient for rude, inappropriate, or egregious behavior, noncompliance with treatment recommendations, failure to obtain medically necessary referrals or further testing, failure to follow medication regimens, failure to meet financial obligations, or breakdown of the physician/patient relationship.

Patient Name (print): ____

Patient Signature: ____

Date: _____________________________________ **Time:** _______________________________________

Legal Guardian Name (print): ____

Legal Guardian Signature: ____

Date: _____________________________________ **Time:** _______________________________________

Patient Name: ___________________________________
Patient DOB: ___________________________________

OUR LADY OF THE LAKE
REGIONAL MEDICAL CENTER
Franciscan Missionaries of Our Lady Health System

New Patient History Form (patients 12 years and older)

Please complete, sign and date this form to allow us to obtain, update and verify information on your medical conditions.
NOTE: IF AN ANSWER IS "NONE" OR N/A, PLEASE INDICATE IN THE SPACE PROVIDED.

Patient Name____ Date of Birth______________________________________

Please list all allergies to medications you may have, including Latex____

Other serious allergic reactions____

Please list all surgeries, admissions to a hospital, or medical facility, or any medical procedures you have had: (Female patients please include OB/GYN procedures)

Surgery/Procedure Date Physician

____ ________________
____
____ ________________
____
____ ________________
____
____ ________________
____

Personal Medical History of disease (Circle if YES): HEART LUNG KIDNEY DIABETES ASTHMA LIVER

Please list all other chronic or ongoing medical conditions that have been diagnosed:

____________________________________ __________________________________
____
____________________________________ __________________________________
____

FEMALE PATIENTS please complete: Number of pregnancies __________ Number of live births ___________

Patient Name: ________________________________
Patient DOB: ________________________________

Family Med. History (Circle if YES): HEART LUNG KIDNEY DIABETES ASTHMA LIVER CANCERS OTHER:

Please give details of all items circled above:
____

____

____

Tobacco Never smoked________ Currently smokes ______pk/day Quit date________ (_____years smoked/ _____packs)

Alcohol Never_______ Occasionally_________ Frequently _______ Daily_______ Quit date_________

____

____
Patient's Signature: I hereby certify this to be true, complete and accurate to the best of my knowledge. Date form completed

Doctor's initials and date when reviewed____

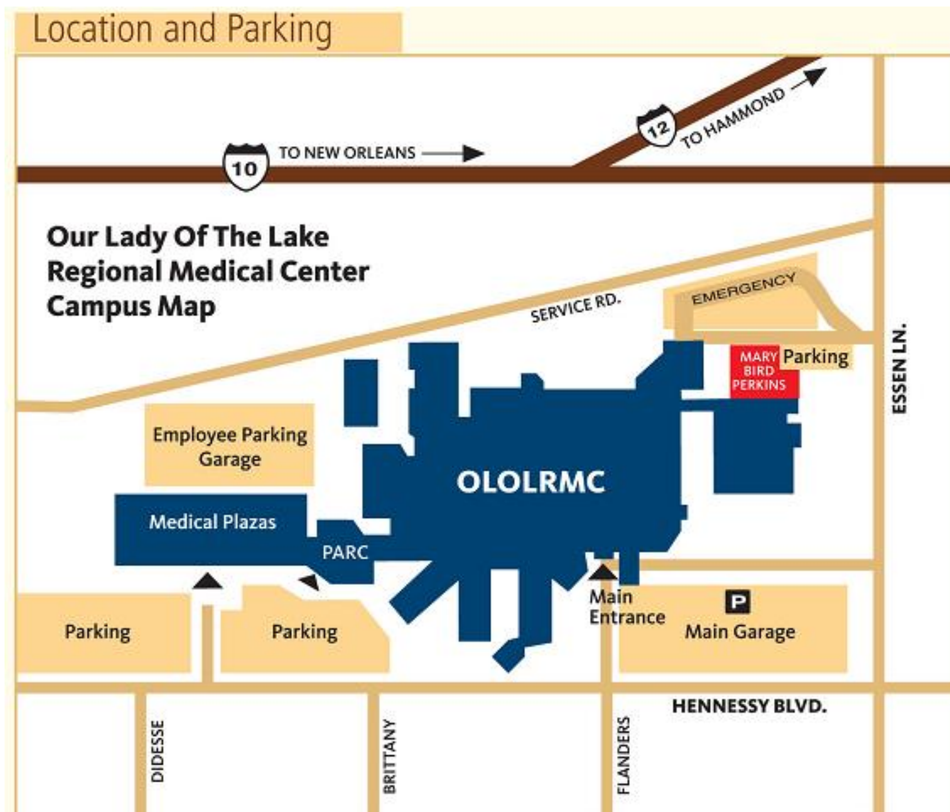
Patient Name: ________________________________
Patient DOB: ________________________________

Patient Name: ______________________________
Patient DOB: ______________________________

OLOL Head and Neck Center

The OLOL Head and Neck Center is located on the fourth floor of Mary Bird Perkins Cancer Center, which is located next to Our Lady of the Lake Regional Medical Center. OLOL Head and Neck Center is located off I-10 at Essen Lane (exit 160) at 4950 Essen Lane, Suite 400, Baton Rouge, LA 70809 (see map below). Patient and visitor parking for OLOL Head and Neck Center is provided in the parking garage next to Mary Bird Perkins. To park, enter Constantin Avenue (at the Emergency Room entrance) and follow the driveway to the **left (not up)** and pull up to the speaker box at the gate to any parking lot.

If you have questions, please call the front desk 225-765-1765.



Patient Name: ________________________________
Patient DOB: ________________________________

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PERSONAL REPRESENTATIVE DESIGNATION FORM

The Health Insurance Portability and Accountability Act of 1996 gives you the right to have one or more persons act as your representative to make decisions about the uses and sharing of health information about you. This form tells us that you have named this person as your authorized personal representative. You can limit the amount of information that the authorized personal representative can decide about, and you can cancel this at any time.

DESIGNATION SECTION

I, ____, hereby name the following person(s) to act as my authorized personal representative(s) with respect to decisions involving the use of and/or the sharing of health information that pertains to me.

Name: ____

Last *First* *MI*

Relationship to Patient: ____________________ **Relationship to Patient:** ______________________

Mailing Address: __________________________ **Mailing Address:** ____________________________

City/State/Zip: ___________________________ **City/State/Zip:** _____________________________

Primary Phone: ____________________________ **Primary Phone:** _____________________________

Please provide a password or other unique identifier that your personal representative(s) must provide during phone inquiries (example: last four digits of your MRN). _________________________________

Patient Name: ______________________________

Patient DOB: ______________________________

INFORMATION PERMISSIONS

Please check one of the below to indicate the type(s) of information you would like shared with your personal representative(s).

- ❑ Financial and demographic information only (billing records, address/phone number changes, etc.)
- ❑ Healthcare information only (health/illness information, HIV/AIDS status, mental health records, coordination of care, compliant resolution, etc.)
- ❑ Financial, demographic and health information
- ❑ Other: ____

I understand that I may cancel this designation at any time by signing the revocation section of my copy of this form and returning it to the Health Information Management department.

I understand that any cancellation can only apply to future disclosures or actions regarding my health information and cannot cancel actions taken or disclosures made while the designation was in effect.

The expiration date for this designation, if no date is specified, is 365 days following the date below.

Patient Name (print): ____

Patient Signature: ____

Date: ____________________________________ **Time:** ______________________________________

REVOCATION

I no longer want the personal representative(s) listed on this form to act as my personal representative(s).

Patient Name (print): ____

Patient Signature: ____

Date: ____________________________________ **Time:** ______________________________________

Patient Name: ________________________________
Patient DOB: ________________________________

NOTICE OF PRIVACY PRACTICES

Effective: April 14, 2003

Revision Date: August 1, 2013, June 6, 2019

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED ANDDISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices (the "Notice") describes the legal obligations of the Franciscan Missionaries of Our Lady Health System and its covered entity affiliates (the "Organization") and your legal rights regarding protected health information held by the Organization under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). HIPAA protects only certain health information known as "protected health information." Generally, protected health information is individually identifiable health information, including demographic information, collected from you, or created or received by a health care provider, a health care clearinghouse, a health plan, or your employer on behalf of a group health plan, that relates to your past, present or future physical or mental health condition or the payment for health care services. This information can be transmitted or maintained in any form by the Organization.

WHO WILL FOLLOW THIS NOTICE?

This Notice describes the Organization's practices and that of:

- All employees, staff, volunteers, contractors, and other personnel.
- All departments and units of the Organization.
- Any member of a volunteer group we allow to help you while you are in our care.
- Any physician or allied health professional who is a member of the Medical Staff and involved in your care.
- All entities, sites and locations will follow the terms of this Notice. When this Notice refers to "we" or "us", it is referring to the following entities, sites, and locations. In addition, these entities may share medical information with each other for treatment, payment or health care operations purposes described inthis Notice.

The Organization, its' Medical Staff, and other health care providers affiliated with the Organization participate in an Organized Health Care Arrangement (OHCA) under HIPAA for the purpose of sharing protected health information for treatment, payment, and health care operations. Participants include Our Lady of the Angels Hospital, Our Lady of the Lake Regional Medical Center, Our Lady of Lourdes Regional Medical Center, Heart Hospital of Lafayette, St. Francis Medical Center, St. Dominic Hospital, Senior Services, Health Centers in Schools, Affiliated Organization Physician Groups, Health Leaders Network Next Generation ACO, Community Connect and RX One. Pleasenote that this list is not all inclusive.

In addition, the Organization utilizes a HIPAA compliant unified electronic medical record system to support efficient care, services and to promote healthcare continuity. Finally, designated facilities within the organization serve as teaching sites for LSU Health Sciences Center. LSU faculty are clinically integrated at sites of care for training and educational purposes.

OUR PLEDGE REGARDING HEALTH INFORMATION:

We understand that medical information about you and your health is personal. We are committed to protecting health

information about you. We create a record of the care and services you receive at our Organization. We need this record to provide you with quality care and to comply with certain legal requirements. This Notice applies to all the records of your care generated by our Organization, whether recorded in your medical record, invoices, payment forms, videotapes or other ways, that include protected health information. Physicians and other care providers who are not employed by the Organization may have different policies or notices regarding the use and disclosure of your protected health information created in the physician's office or clinic.

ACKNOWLEDGMENT OF RECEIPT OF THIS NOTICE

You will be asked to provide a signed acknowledgement of receipt of this Notice. Our intent is to make you aware of the possible uses and disclosures of your protected health information and your privacy rights. The delivery of health care services will in no way be conditioned upon your signed acknowledgement. If you decline to provide a signed acknowledgement, we will continue to provide your treatment, and will use and disclose your protected health information for treatment, payment, and health care operations when necessary.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

In some circumstances we are permitted or required to use or disclose your protected health information without obtaining your prior authorization and without offering you the opportunity to object. The following categories describe these different circumstances. For each category of uses or disclosures we will explain what we mean and list an example. Not every use or disclosure in a category will be listed. However, all the ways we are permitted to use and disclose information will fall within one of the categories.

- **For Treatment**. We may use and disclose your protected health information to provide you with medical treatment or services. We may disclose your protected health information to doctors, nurses, technicians, medical students, or other health care providers who are involved in taking care of you. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. In addition, the doctor may need to tell the dietitian if you have diabetes so that we can arrange for appropriate meals. Different departments of the hospital also may share medical information about you in order to coordinate the different things you need, such as medications, lab work and x-rays andwe may disclose your protected health information to third parties with whom we coordinate and manage your care.

- **For Payment**. We may use and disclose your protected health information so that the treatment and services you receive at the hospital may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may inform your health insurance company of your diagnosis and treatment in order to assist the insurer in processing our claim for the health care services provided to you or share information with a person who helps pay for your care.

- **For Health Care Operations**. We may use and disclose your protected health information for our day-to-day operations and functions. For example, we may compile your protected health information, along with that of other patients, in order to allow a team of our health care professionals to review that information and make suggestions concerning how to improve the quality of care provided at our organization. We may also disclose information to doctors, nurses, technicians, medical students, membersof our quality improvement team, and other participants in our organized health care arrangements for review and learning purposes and to improve the quality and effectiveness of the services you receive. The entities and individuals covered by this Notice may share information for their joint health care operations.

- **To Business Associates**. We may contract with individuals or entities known as Business Associates to perform various functions on our behalf or to provide certain types of services. In order to perform

thesefunctions or to provide these services, Business Associates will receive, create, maintain and/or transmit protected health information about you, but only after they agree in writing with us to implement appropriate safeguards regarding your protected health information.

- **Health Information Exchange**. We may share your information for treatment, payment, and healthcare operations purposes through a Health Information Exchange (HIE) in which we participate in order for participants to efficiently access and use your pertinent medical information necessary for treatment and other lawful purposes. A HIE is a secure electronic system that helps health care providers and entities suchas health plans and insurers managed care and treat patients. We will send your health information to the Epic Care Everywhere HIE, the Cerner CommonWell HIE and other HIEs as we choose to participate in them. Information about your past medical care and current medical conditions and medicines is available not only to us but also to non-Organization health care providers who participate in the HIE. You have the right to opt out of the HIE. However, even if you do, some of your health information will remain availableto certain health care entities as permitted by law.

- **Appointment Reminders**. We may contact you as a reminder that you have an appointment for treatmentor medical care at our organization.

- **Treatment Alternatives**. We may contact you about or recommend possible treatment options oralternatives that may be of interest to you.

- **Health-Related Benefits and Services**. We may contact you about health-related benefits or services such as disease management programs and community-based activities in which we participate that may be of interest to you.

- **Fundraising Activities**. We may contact you as part of our effort to raise funds for our organization. You have a right to opt out of receiving fundraising communications and all fundraising communications will include information about how you may opt out of future communications.

- **Research**. Under certain circumstances, we may use and disclose your protected health information for research purposes through a special approval process designed to protect patient safety, welfare, and confidentiality. This process evaluates a proposed research project and its use of medical information, trying to balance the research needs with patients' need for privacy of their medical information. For example, a research project may involve comparing the health and recovery of all patients who received onemedication to those who received another, for the same condition. We may also disclose your protected health information to people preparing to conduct a research project, for example, to help them look for patients with specific medical needs, so long as the information they review does not leave the hospital.

- **As Required By Law**. We will disclose your protected health information when required to do so by federal, state, or local law.

- **To Avert a Serious Threat to Health or Safety**. We may use and disclose your protected health information when necessary to prevent a serious threat to your health and safety or the health and safety ofthe public or another person. Any disclosure, however, would only be to someone able to help prevent thethreat.

SPECIAL SITUATIONS

- **Organ and Tissue Donation**. If you are an organ donor, we may disclose your protected health information to organizations that handle organ procurement or organ, eye or tissue transplantation or

to anorgan donation bank, as necessary to facilitate organ or tissue donation and transplantation.

- **Military and Veterans**. If you are a member of the armed forces, we may disclose your protected health information as required by military command authorities. We may also release health information about foreign military personnel to the appropriate foreign military authority.

- **Workers' Compensation**. We may disclose your protected health information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

- **Public Health Risks**. We may disclose your protected health information for public health activities. These activities generally include the following:

  - to prevent or control disease, injury or disability;
  - to report births and deaths;
  - to report to state and federal tumor registries;
  - to report child abuse or neglect;
  - to report reactions to medications or problems with products;
  - to notify people of recalls of products they may be using;
  - to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
  - to provide proof of immunization to a school that is required by state or other law to have such proof withagreement to the disclosure by a parent or guardian of, or other person acting in loco parentis for an un-emancipated minor;
  - to notify the appropriate government authority if we believe that a patient has been the victim of abuse,neglect, or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

- **Health Oversight Activities**. We may disclose your protected health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor thehealth care system, government programs, and compliance with civil rights laws.

- **Judicial and Administrative Proceedings.** We may disclose your protected health information in response to and in accordance with a court or administrative order. We may also disclose your protected health information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute after we have received assurances that efforts have been made to tell you about therequest or to obtain an order protecting the information requested.

- **Law Enforcement**. We may disclose your protected health information if asked to do so by a law enforcement official:
  - In response to a court order, subpoena, warrant, summons or similar process;
  - To identify or locate a suspect, fugitive, material witness, or missing person;
  - About the victim of a crime if, under certain limited circumstances, we are unable to obtain the victim'sagreement;
  - About a death we suspect may be the result of criminal conduct;
  - About criminal conduct at the Organization; and
  - In emergency circumstances to report a crime; the location of the crime or victims; or the identity,description or location of the person who committed the crime.

- **Coroners, Medical Examiners and Funeral Directors**. We may disclose your protected health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceasedperson or to determine cause of death. We may also release health information about patients of the Organization to funeral directors as necessary to carry out their duties.

- **Inmates**. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose your protected health information to the correctional institution or law enforcement official. This release would be permitted (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security ofthe correctional institution.

- **National Security and Intelligence Activities**. We may release your protected health information to authorized federal officials for intelligence, counterintelligence and other national security activities authorized by law.

We may also use or disclose your protected health information in the following circumstances. However, except in emergency situations, we will inform you of our intended action prior to making any such uses and disclosures and will, at that time, offer you the opportunity to object.

- **Hospital Directory**. We may include certain limited information about you in the hospital directory while you are a patient at the hospital. This information may include your name, location in the hospital, your general condition (e.g., fair, stable, etc.) and your religious affiliation. The directory information, except for your religious affiliation, may also be released to people who ask for you by name. Your 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. This is so your family, friends and clergy can visit you in the hospital and generally know how you are doing.

- **Individuals Involved in Your Care or Payment for Your Care**. We may disclose your protected health information to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. We may also tell your family or friends your condition and that you are in the hospital. In addition, we may disclose your protected health information toan entity assisting in a disaster relief effort so that your family can be notified about your condition, status, and location.

With few exceptions, we must obtain your written authorization for uses and disclosures of your protected health information involving (1) certain marketing communications about a product or service and whether financial remuneration is involved, (2) a sale of protected health information resulting in remuneration not permitted under HIPAA; and (3) psychotherapy notes, except for certain treatment, payment and health care operations purposes, if the disclosure is required by law or for health oversight activities, or to avert a serious threat.

Except as permitted under HIPAA or as described above, disclosures of your protected health information will be made only with your written authorization. You may revoke your authorization at any time, in writing, unless we have acted in reliance upon your prior authorization, or if you signed the authorization as a condition of obtaining insurance coverage.

Patient Name: ______________________________
Patient DOB: ______________________________

YOUR RIGHTS:

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

- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose informationabout a surgery you had.

  Except as provided below, we are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

  Effective September 23, 2013, we will comply with any restriction request if (1) except as otherwise required by law, the disclosure is to a health plan for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment); and (2) the protected health information pertains solely to a health care item or service for which the Organization has been paid out-of-pocket in full. The Organization is not responsible for notifying subsequent healthcare providers of your request for restrictions on disclosures to health plans for those items and services, so you will need to notify other providers if you want them to abide by the same restriction.

  To request restrictions, you must make your request in writing to the Privacy Officer of your facility as designated below. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

- **Right to Request Confidential Communications**. You have the right to request that we communicate with you about health matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

  To request confidential communications, you must make your request in writing to the Privacy Officer of your facility as designated below. Your request must specify how or where you wish to be contacted. We will not ask you the reason for your request. We will accommodate all reasonable requests.

- **Right to Inspect and Copy Health Information**. You have the right to inspect and copy protected health information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes, information complied in anticipation of or for use in civil, criminal, or administrative proceedings, or certain information that is governed by the Clinical Laboratory Improvement Act. If the requested protected health information is maintained electronically and you request anelectronic copy, we will provide access in an electronic format you request, if readily producible, or if not, in a readable electronic form and format we mutually agree upon. We may charge a reasonable cost-based fee consistent with HIPAA and applicable state law.

  Despite your general right to access your protected health information, access may be denied in limited circumstances. For example, access may be denied if you are an inmate at a correctional institution or if you are a participant in a research program that is still in progress. Access may be denied if the federal Privacy Act applies. Access to information that was obtained from someone other than a health care provider under a promise of confidentiality can be denied if allowing you access would reasonable be likely to reveal the source of the information. The decision to deny access under these circumstances is final and not subject to review. Otherwise, we will provide a written explanation on the basis for the denial and your review rights.

  To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the Medical Records Department of your facility as designated below. If you request a copy of the information, in accordance with applicable state law, you will be charged a fee for the costs of copying,

mailing or other supplies associated with your request.

- **Right to Request Amendment**. If you feel that protected health information, we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long asthe information is kept by or for the Organization. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us toamend information that:

  - Was not created by us, unless the person or entity that created the information is no longer available tomake the amendment;
  - Is not part of the medical information kept by or for the hospital;
  - Is not part of the information which you would be permitted to inspect and copy; or
  - Is accurate and complete.

  To request an amendment, your request must be made in writing and submitted to the Medical Records Department of your facility as designated below. In addition, you must provide a reason that supports your request. If we deny your request, you have the right to file a statement of disagreement with us and any future disclosures of the disputed information will include your statement.

- **Right to an Accounting of Disclosures**. You have the right to request an "accounting" of certain disclosures of your protected health information made during the six-year period preceding the date of your request. However, the following disclosures will not be accounted for: (i) disclosures made for the purpose of carrying out treatment,payment or health care operations unless HIPAA provides otherwise, (ii) disclosures made to you, (iii) disclosuresof information maintained in our patient directory, or disclosures made to persons involved in your care, or for thepurpose of notifying your family or friends about your whereabouts, (iv) disclosures for national security or intelligence purposes, (v) disclosures to correctional institutions or law enforcement officials who had you in custody at the time of disclosure, (vi) disclosures that occurred prior to April 14, 2003, (viii)disclosures made pursuant to an authorization signed by you, (viii) disclosures that are part of a limited data set, (ix) disclosures thatare incidental to another permissible use or disclosure, or (x) disclosures made to a health oversight agency or lawenforcement official, but only if the agency or official asks us not to account to you for such disclosures and only for the limited period of time covered by that request. The accounting will include the date of each disclosure, thename of the entity or person who received the information and that person's address (if known), and a brief description of the information disclosed and the purpose of the disclosure for the period requested unless the period or right to receive the accounting is limited under HIPAA.

  To request this list or accounting of disclosures, you must submit your request in writing to the Medical Records Department of your facility as designated below. Your request must state a time period. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a 12-month period will be free. For additional lists, we will 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 at that time before any costs are incurred.

Right to a Paper Copy of This Notice.

You have the right to a paper copy of this Notice. You may obtain a copy of this Notice at the websites designated below. To obtain a paper copy of this Notice, contact the Compliance and Privacy Officer as designated below.

OUR DUTIES

- We are required by law to make sure that health information that identifies you is kept private;
- We are required to provide you this Notice of our legal duties and privacy practices;
- We are required to notify you in the event that we discover a breach of unsecured protected health information, asthat term is defined under federal law; and

Patient Name: ________________________________
Patient DOB: ________________________________

- We are required to follow the terms of this Notice. We reserve the right to change the terms of this Notice and tomake those changes applicable to all protected health information that we maintain. Any changes to this Notice will be posted on our website and at our facility and will be available from us upon request.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the U.S. Department of Health and Human Services. To file a complaint with us, please contact the Patient Advocate as designated below. All complaints must be submitted in writing. You will not be penalized, or in any other way retaliated against, for filing a complaint.

CONTACT INFORMATION

Our Lady of the Angels
433 Plaza St., Bogalusa, LA 70427
(985) 730-6800
www.oloah.org

Our Lady of Lourdes Regional Medical Center
4801 Ambassador Caffery Parkway, Lafayette, LA 70508(337) 470-2100
www.lourdesrmc.com

Our Lady of the Lake Regional Medical Center
5000 Hennessy Blvd.,
Baton Rouge, LA 70808 (225) 765-4321
www.ololrmc.com

St. Francis Medical Center
309 Jackson St., Monroe, LA 71201
(318) 966-4000
www.stfran.com

St. Dominic Hospital
969 Lakeland Drive, Jackson, MS 39216
(601) 200-2000
www.stdom.com

Patient Name: ________________________________
Patient DOB: ________________________________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received your Notice of Privacy Practices.

Printed Patient or Patient Representative Name: ______________________________

Relationship to Patient (if signing for the patient): ______________________________

Signature: ______________________________

Date: ______________________________

FOR OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices acknowledgement,but was unable to do so as documented below:

REASON(S):____
____________________ ____

Employee Name and Date: ____

Patient Name: ________________________________

Patient DOB: ________________________________

Patient Rights and Responsibilities

As a patient, you and your family are important to us. During your visit, you have rights and responsibilities.

As a patient, you have the right to . . .

Personal Privacy and Visitation

- Be treated with dignity and respect.
- Keep your health information confidential per state and federal law.
- Have your health information shared only with those who need to know so they can assist in your care.
- Have your personal privacy honored.
- Have a family member, friend, or other person with you to provide emotional support unless doing so is disruptive.
- Say yes or no to the making of recordings, films, or other images of you for purposes other than identification, diagnosis, or treatment.

Security and Safety

- Be free from mistreatment; neglect; exploitation; and verbal, mental, physical, and sexual abuse while receiving care, treatment, and services.
- Get protective, supportive and advocacy services.
- Get care in a safe setting that preserves dignity and meets your personal needs.
- Know restraints or seclusion will be used only when medically needed.

Cultural and Spiritual Values

- Have your customs and personal values, beliefs and preferences respected.
- Receive religious and other spiritual services.

Receive Care and Support

- Be able to talk and interact with people who know how to help when you have questions or problems.
- Receive safe, quality care in a timely manner that is flexible and respectful to your interests and needs.
- Be able to participate in your discharge planning and be provided with information on how to have your care needs met at home.
- Be provided information on resources and services as needed.
- Receive care and services in a professional manner without being discriminated, excluded, or treated differently because of race, color, ethnic origin, age, physical or mental disability, sex, religion, culture, language, socioeconomic status, sexual orientation and gender identity or expression.

Information

- Tell us about yourself, what you need and how you feel.
- Make, check, or change your Living Will and have it honored in line with law, regulations, and the hospital's capabilities.

- Ask, if admitted to the hospital, that we inform a family member or representative of your choice as well as your own doctor of your admission.
- Know the names and roles of those responsible for the delivery of your care and treatment.
- Be able to identify all employees through proper identification.
- Have your healthcare team partner with you and your family to plan care and acknowledge your needs, ideas, and concerns.
- Have your healthcare team meet with you and your family so you can be informed of your health status and be involved in choices that affect you, including the right to say no to care, treatment, and services.
- Have your family or representative involved in your care, treatment, and service choices when you are notable to make these choices, as allowed by law.
- Be informed of your responsibilities for your care, treatment, and services.
- Be informed about the results of care, treatment, and services so you can participate in current/future healthcare choices.
- Get information from your clinical records.
- Have your wishes followed about organ donation, when you make such wishes known, in agreement with law/regulations.
- Be safe and have your rights respected during research, investigative and clinical studies.
- Have access to information on disclosures of personal health information, under law regulations
- To receive information about your care in a manner and language you understand:
  - Access to free aids and services for people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats {large print, audio, accessible electronic formats, other formats).
  - Free language services for those whose primary language is not English, such as qualified interpreters and information written in other languages.
  - If you need these services, please contact Patient Care Services at (225) 765-8828.
  - ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüíst ica. Llame al (225) 765-8828.
  - ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le (225) 765-8828.

Pain Management

- Be asked about your pain and know staff will work with you to plan so you can be as comfortable as possible.

Express Concerns, Complaints or Grievances

- Be able to safely express feelings and concerns when afraid or hurting.
- Express concerns about any aspect of your care, treatment, and services. To express concerns, complaints and/or a grievance as a patient with Our Lady of the Lake Regional Medical Center, Our Lady of the Lake Ascension, Our Lady of the Lake Children's Hospital, Our Lady of the Lake Livingston, Our Lady of the Lake North Baton Rouge, and Our Lady of the Lake Assumption Community Hospital:
  - You may call (225) 765-8450.
  - If you failed to receive services or were discriminated on the basis of race, color, national origin, age, disability or sex, you can file a grievance in person, by mail or email with Civil Rights Coordinator Tammi Aidt, Our Lady of the Lake RMC, 5000 Hennessy Blvd., Baton Rouge, LA 70802, civilrights@ololrmc.com, (225) 765-3295, (225) 765-9279 (fax).
  - You can also file a civil rights complaint with the U.S. Department of Health and Human Services (HHS), Office for Civil Rights, electronically through the office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at HHS, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201, (800) 368-1019, (800) 537-7697 (TDD).
  - Louisiana Department of Health Hospital Complaint Desk, Health Standards Section, P.O. Box 3767, Baton Rouge, LA 70821 or call (225) 342-6429. Medicare beneficiaries may call (800) 315-0636.
- Patient safety concerns can be reported to the Joint Commission:
  - At www.jointcommission.org, using the "Report a Patient Safety Event" link in the "Action Center" on the home page of the website.
  - By mail to the Office of Quality and Patient Safety, The Joint Commission, One Renaissance Boulevard, Oakbrook Terrace, IL 60181.
- To express concerns, complaints and/or a grievance as a patient with Our Lady of the Lake Physician Group:
  - You may call (225) 765-1573
  - If you failed to receive services or were discriminated on the basis of race, color, national origin, age, disability or sex, you can file a grievance in person, by mail or email with Civil Rights Coordinator Kaki Strange, Franciscan Missionaries of Our Lady Health System, 4200 Essen Lane, Baton Rouge, LA 70809, ololpgcivilrights@ololrmc.com, (225) 765-1573, (225) 765-9998 (fax).

Patient Name: ______________________________

Patient DOB: ______________________________

As a patient, you have the responsibility to . . .

Give Pertinent Information

- Give us complete and accurate health information about your past and present health, changes in your health problem or symptoms including pain and all drugs you are taking.
- Give us complete and accurate personal information including name, address, phone number, date of birth, social security number and health insurance coverage.
- Give us a copy of your Living Will if you have one.
- Give us a copy of any legal document related to decision making.
- Tell us if you need a translator or translation services.

Ask Questions and Partner with Healthcare Team

- Speak up. Let us know if you do not understand the information we give you about your condition, treatment, procedures, or drugs.
- Work with your doctor, nurse, and other healthcare providers to make choices about your care and work with your healthcare team to implement.
- Tell your concerns to any team member as soon as possible.

Be Responsible

- Request information regarding your bill. Pay your bill or make financial arrangements.
- Leave your personal belongings at home or have someone take all valuables home.

Show Respect and Consideration

- Respect the knowledge and skills of your healthcare team.
- Keep your scheduled appointments and call us if you need to reschedule.
- Be thoughtful and helpful by treating everyone with courtesy and respect. Any abusive or rude behavior could result in your dismissal from our care.
- Not smoke or use tobacco products, including e-cigarettes on our property.
- Not leave your care area without talking with staff.
- Respect the rights and property of others and the building.
- Not bring illegal drugs, alcohol, guns, or other weapons onto our property.
- Not take photos or videos of hospital or clinic staff, other patients, or people.