Hoover Family Medicine

Dedicated to Your Health!

PATIENT REGISTRATION FORM

PATIENT INFORMATION (PLEASE PRINT)

Today's Date:		**Social Security Number:**	
Last Name:	**First:**	**Middle:**	**Home Phone Number:** ( )
Street Address:			**Cellular Phone Number:** ( ) **Carrier:**
City:	**State:**	**Zip Code:**	**Work Phone Number:** ( )
E-Mail Address:			**Date of Birth:** / **Gender:** ☐ M ☐ F
If Under 18, Parent/Guardian's Name:			**Contact Number:** ( )

How Did You Hear About Hoover Family Medicine? ☐ Family ☐ Friend ☐ Flyer ☐ Hoover Family Medicine staff ☐ Internet ☐ Homeless Shelter ☐ Schools ☐ Local Organization ☐ Health Fair ☐ Other: _____

EMERGENCY CONTACT [IN CASE OF EMERGENCY, PERSON WE MAY CONTACT]

FIRST AND LAST NAME: _____

PHONE NUMBER: _____

RELATIONSHIP TO PATIENT: ☐ Spouse ☐ Child ☐ Parent ☐ Other: _____

PATIENT DEMOGRAPHICS (PLEASE ANSWER ALL QUESTIONS)

Ethnicity: ☐ Hispanic/Latina(o) ☐ Non-Hispanic/Latina(o) ☐ Prefer not to Report

Race: ☐ Black/African American ☐ White ☐ Asian ☐ Hawaiian ☐ American Indian/Alaska Native ☐ Pacific Islander ☐ Prefer not to Report

Preferred Language: If you prefer to communicate in a language other than English, please list preferred language:_____. ☐ **I request interpretation services**

Veteran? ☐ Yes ☐ No	**Seasonal Worker (In the Area Temporarily)?** ☐ Yes ☐ No	**Current Housing Status?** ☐ Own ☐ Rent ☐ Staying with Family ☐ Staying with Friends ☐ Shelter ☐ Living In Car ☐ Transitional Housing ☐ Living Outdoors ☐ Other: _____

Marital Status? ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widow

Employed? ☐ Yes ☐ No	**Name of Employer:**

INSURANCE INFORMATION [IF NOT INSURED, SKIP THIS SECTION]

Insurance Name: _____ _____	Insurance ID: _____ Group#:	Policy Holder's Name: _____ Date of Birth:

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Patient Name_____ Birth Date_____

PATIENT CONSENT FOR TREATMENT

By signing below, I, (or my authorized representative on my behalf) authorize Hoover Family Medicine Providers and their staff to conduct any diagnostic examinations, tests and procedures, as well as provide any medications, treatment or therapy necessary to effectively assess and maintain my health, to assess, diagnose and treat my illness or injuries. I understand that, excluding emergencies or extraordinary circumstances, it is the responsibility of my individual treating health care Providers to explain to me the reasons for any particular diagnostic examination, test or procedure, the available treatment options and the common risks and anticipated burdens and benefits associated with these options as well as alternative courses of treatment.

Right to Refuse Treatment: In giving my general consent to treatment, I understand that I retain the right to refuse any particular examination, test, procedure, treatment, therapy or medication recommended or deemed medically necessary by my individual treating health care Providers. I also understand that the practice of medicine is not an exact science and that no guarantees have been made to me as to the results of my evaluation and/or treatment.

HIV, Hepatitis B & C Testing

In the event that Hoover Family Medicine staff comes in contact with my or my children's body fluids,
I,_____, consent to be tested for HIV, Hepatitis B and C.
(Initials)

Signature:_____ _____
Patient/Parent/Legal Guardian Signature Date

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PATIENT REGISTRATION FORM

Patient Name_____ Birth Date_____

FINANCIAL RESPONSIBILITY AGREEMENT

Payment is expected at time of service. Payment may be made by cash, check, or major credit card. Any fees, deductibles, co-insurance, or co-payment is payable at time of service.

PAYMENT RESPONSIBILITY: The undersigned assumes responsibility for payment for services in accordance with the standard rates and terms of Hoover Family Medicine, whether to sign as a patient or guarantor, **where insured or uninsured**. As the undersigned, I fully understand: (a) my insurance, if any, is a contract between myself and the insurance company, except in certain cases where Hoover Family Medicine has a specific contract with my PPO, HMO, or other third party payer; **Hoover Family Medicine does not explain nor determine if services are covered by my insurance, if any, so any inquiries to explain or determine insurance coverage for services are between myself and the insurance company**; (b) any balance remaining after insurance, if any, approves or denies payment is my responsibility to pay; **if my insurance company denies a claim for services for any reason, whether at the time or subsequent to receiving services, I assume full responsibility for payment in accordance with the standard rates and terms of Hoover Family Medicine**.

In the event all charges for services are not paid in full when due, whether insured or uninsured, and collection activity is instituted, whether by a collection agency or an attorney (or both), I agree to be responsible for balance of charges for services and treatment received and all costs reasonably associated with such collection activity including, but not limited to, reasonable collection fees, attorney's fees, and court costs.

I hereby authorize Hoover Family Medicine to release all medical information to all my insurance carriers, other third party payers, including Medicare or its agents, or the Social Security Administration, as may be required or requested for the processing of claims for insurance, social security, disability, or Worker's Compensation or other insurance purposes.

AUTHORIZATION TO PAY INSURANCE BENEFITS

I hereby authorize the payment of any insurance or other medical benefits directly to Hoover Family Medicine. The undersigned, having read and understood the agreement, accepts this financial responsibility agreement.

Signature: _____ _____

Patient / Parent / Legal Guardian Signature Date

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PATIENT REGISTRATION FORM

Patient Name_____ Birth Date_____

PERMISSION TO RELEASE & EXCHANGE INFORMATION

Hoover Family Medicine creates and receives confidential records regarding your health while under our care. Hoover Family Medicine will not release your confidential records to any individual or organization (including family members), without your express, written permission. This policy includes written consent for us to refer you to a specialist outside of our office.

☐ I consent to the release and exchange of confidential records to family members, organizations and referral sources requesting it.

☐ I consent for the Provider to obtain my prescription history from external sources.

☐ I consent to the release of confidential records, medical results or medications to the named individuals and organizations listed as follows: _____

☐ I consent for an employee to discuss my billing account with my spouse, family member, or significant other. If allow, only those listed here:_____

Method of Contact:

Please select the method(s) Hoover Family Medicine is allowed to contact you for appointment reminders, test results, billing, etc.

☐ I may be contacted by phone (at the numbers I provide)

☐ I may be contacted by text message Cell phone Carrier: _____ (required)

☐ I may be contacted by email

Patient Portal:

The Patient Portal allows for patients to review existing appointments, lab results, medications, request prescription refills, medical history, patient statements and send secure messages to Hoover Family Medicine staff. To enroll in this internet-based option, please click the box below. The email address provided on the Patient Enrollment Form will be used as your log-in.

☐ Enroll me

Signature: _____ _____

Patient / Parent / Legal Guardian Signature Date

Hoover Family Medicine

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PATIENT REGISTRATION FORM

Patient Name_____ Birth Date_____

HOOVER FAMILY MEDICINE POLICIES

Patients can find the full text of Policies listed below at each facilities Front Desk and on the HFM Website

Medication Refill Policy

Hoover Family Medicine requires at least five (5) business days notice for general medications to be refilled. Many of the medications given to you must be closely monitored for effectiveness and side effects. Depending on your condition, if you have not been seen by your practitioner within a specified time period, medications may be declined, or only be prescribed for 30 days to allow you time to schedule an appointment with your physician/practitioner. Please try not to run out of medication prior to requesting a refill. Ensuring that your medication refills are up-to-date at every clinic visit is the safest, most efficient way to ensure you do not run out of essential medications.
Medications may NOT be refilled after office hours or on the weekends. Prescriptions for medications that we have not previously prescribed for you will NOT be filled.

Paperwork Request Policy

Please allow 7-10 business days for completion of any paperwork. In certain situations, an additional office visit may be required for certain types of paperwork to be completed.

Referral Policy

Hoover Family Medicine often utilizes the use of specialty clinics. If you know of a specialty clinic you would like to be set up with, please inform our staff before you leave the office. If you do not know of a specialty clinic you would like to go to, it is your responsibility to contact your insurance company and find an appropriate specialist. It is then your responsibility to contact us with the information so we can then send your referral. If you need to reschedule the appointment time we set up for you it is up to you to contact the specialty clinic to do so. Many insurance companies require the addition of specified tests and/or procedures before a referral can be made. An additional office visit may be required to ensure all requirements are met for individual policies. An employee may also contact you to gather additional information if required. Please allow 7-10 business days for a referral to be sent. Please keep in mind a referral may take additional time if further information is required.

Signature: _____ _____

Patient / Parent / Legal Guardian Signature Date

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PATIENT REGISTRATION FORM

Patient Name_____ Birth Date_____

HOOVER FAMILY MEDICINE POLICIES

Patients can find the full text of Policies listed below at each facilities Front Desk and on the HFM Website

Notice of Patient Privacy Practices

I understand that as a patient of Hoover Family Medicine, all information collected will be kept confidential under the Health Insurance Portability and Accountability Act (HIPAA) of 1996. I acknowledge that I have received the Notice of Privacy Practices from Hoover Family Medicine.

Appointment Expectations

All patients will be assigned an Appointment Arrival Time for each visit. All payments are expected at time of service. Alert a staff member of any changes in your information to make sure we have the most updated information in your account. Make sure you provide proper identification, required documentations, and insurance cards (if any) at the time of the visit. Minors must be accompanied by an adult at all times.

Appointment Confirmation

You must confirm your appointment no later than 48 hours before the scheduled Arrival Time. If Hoover Family Medicine cannot confirm your appointment, it will be canceled. We will do everything possible to reschedule your appointment depending on the availability of your Provider.

Late Arrival

Patients that **arrive** at the front desk **more than 15 minutes after their scheduled Arrival Time** may not be seen at their scheduled appointment. We will do everything possible to see patients the same day, depending on the availability of your Provider, or will reschedule your appointment .

Cancellation Policy

Patients that need to cancel or reschedule an appointment may do so by calling Hoover Family Medicine or leaving a message at 205-979-3381. **Appointment cancellation requires 24-hour advanced notice.** Voicemail messages left 24 hours in advance will suffice as notification to Hoover Family Medicine. Failure to cancel an appointment will result in a **"no-show"** entry in your record and a **fee of $25.00** will be charged.

Signature: _____ _____

Patient / Parent / Legal Guardian Signature Date

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PATIENT REGISTRATION FORM

Patient Name_____ Birth Date_____

HOOVER FAMILY MEDICINE POLICIES

Family Planning Policy

We at Hoover Family Medicine want to do everything we can to address concerns about your health. However, individuals who have **Alabama Medicaid Family Planning Only** policies have restrictions on the services we are able to provide. Alabama Medicaid Family Planning Only policies will only cover office visits, lab-work, and procedures related to family planning. These services include: Yearly Pap Smears, STD/HIV testing, Contraceptive Management, and Pregnancy testing required for contraceptive management. All other services will not be provided. If you are needing services pertaining to other conditions such as: Hypertension, Sick visit, Diabetes, Abdominal pain, or any other condition not related to family planning you will need to provide other additional insurance to cover the visit or pay out of pocket. It is your responsibility as the patient to know what type of policy you have and what is covered under that policy. If you are seen for a non family planning related visit and only have family planning coverage, you will be responsible for the full cost of the visit.

Primary Care Provider Policy

Your insurance may assign you to a specific provider called your Primary Care Provider (PCP). If you are assigned to a primary care provider by your insurance, you are required to see that specific provider for services. If you are required to have a primary care provider and you want to be seen by any provider in this office, you will need to assign/change your primary care provider to Dr. Shelly Weisenfeld. If you are currently assigned to a different provider but want to be seen today, you can contact your insurance provider to change your assignment before being seen or obtain a referral from your assigned provider requesting permission to be seen by Dr. Shelly Weisenfeld and have them fax it to us at (205) 979-3726. If a referral is sent to us it is then your responsibility to call your insurance and have your assignment changed to Dr. Shelly Weisenfeld if you wish to continue services with us. It is your responsibility as a patient to know if you have an assigned primary care provider, who it is, and if you are eligible for services if you see a different provider. If you are assigned to a provider other than Dr. Shelly Weisenfeld and we do not have a referral from your assigned provider, your claim will be denied, and you will be responsible for the full cost of the visit.

Signature: _____ _____

Patient / Parent / Legal Guardian Signature Date

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PATIENT REGISTRATION FORM

Patient Name_____ Birth Date_____

HOOVER FAMILY MEDICINE NARCOTICS POLICY

Narcotics Policy

Our physician and practitioners are committed to evaluating and treating pain at every visit. There are a multitude of options for treating pain including oral medications, physical therapy, exercise, relaxation techniques, use of heat and/or cold, and acupuncture that we may prescribe or refer patients for. In most cases, treatment of the underlying medical condition will result in alleviation of pain. We offer conservative, narcotic-free treatment of chronic pain that is associated with numerous conditions. Our clinic is not set up for the management of chronic pain with narcotics or opioids. In accordance with recommendations by the *Federation of State Medical Boards*, we will direct those patients in need of the use of controlled substances to pain specialists and experts for further evaluation, treatment, and monitoring.

On some occasions, the use of narcotic medication may be an essential tool in the care of a patient. In accordance with the oversight of the *Alabama Medical Board* which governs safe and effective medical practices, our practices policies are as follows:

1. On a first new patient visit, no narcotics or other controlled substances will be prescribed in the absence of a clear, acute injury.

2. In the interest of safety, patients requiring chronic pain medications must agree to obtain medications from only one physician and one pharmacy.

3. Prescriptions will not be filled outside of normal business hours and will be subject to our customary medication refill policies.

4. New prescriptions will not be written for lost or stolen prescriptions.

5. If all of the prescribed medication is taken prior to the refill date, then the refill request will be denied.

6. Chronic pain or pain beyond that which is normally expected for a specific condition that continues to require narcotic medication will be referred to a pain management clinic.

Signature: _____ _____

Patient / Parent / Legal Guardian Signature Date

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PATIENT REGISTRATION FORM

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

From (Releasing Facility)
Facility Name _____
Address _____
City _____
State & Zip _____
Telephone _____ Fax _____

To (Receiving Facility)
Hoover Family Medicine
3081 Lorna Rd Ste 101
Hoover, AL 35216
Phone: (205) 979-3381
Fax: (205) 979-3726

Patient Information

Patient Name: _____ Date of Birth: _____
Social Security Number: _____ Medical Record Number: _____
Address: _____ Telephone: _____
_____
_____

Please release the following medical/health information:

☐ Complete Medical Record ☐ Radiology (X-rays, MRI, CT) ☐ Other (Please Specify) _____
☐ Clinical Notes ☐ Ultrasound _____
☐ Laboratory Reports ☐ Billing/Accounting _____

Dates of care from _____ **to** _____

The information released may be used for the following purposes: _____
_____

I understand that the information in my health record may include information related to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I hereby release the Receiving Facility and the Releasing Facility from any liability related to the release, use, or disclosure of this information as described herein.

I understand that I may revoke this authorization at any time, and unless expressed otherwise, this authorization shall expire six months from the date of my signature below.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Expiration Date: _____ (If not indicated, expires six months from date signed by patient.)

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PATIENT REGISTRATION FORM

MEDICAL HISTORY

Patient Name_____ Birth Date_____

MEDICATIONS

Please List all Medications you are currently taking:

Medication	Dosage	How is Taken	Frequency

ALLERGIES

Please List all Allergies:

Allergies	Allergies	Allergies

PAST MEDICAL HISTORY

Do you now or have you ever had:

☐ Anemia	☐ Arthritis	☐ Asthma
☐ Cancer (type) _____	☐ Cardiovascular disease	☐ Cataracts
☐ COPD	☐ COVID - 19	☐ Diabetes ☐ Type l ☐ Type ll
☐ Epilepsy / Seizure disorder	☐ Glaucoma	☐ Heart attack
☐ Heart murmur	☐ Hepatitis C	☐ HIV
☐ Hyperlipidemia	☐ Hypertension	☐ Inflammatory Bowel Disease
☐ Irritable Bowel Syndrome	☐ Kidney Disease	☐ Lupus
☐ Migraines	☐ Organ Transplant: _____	☐ Pneumonia
☐ Psoriasis	☐ Scoliosis	☐ Sickle Cell
☐ STD: _____	☐ Stroke	☐ Substance Abuse: _____
☐ Thyroid: ☐ Hyper ☐ Hypo	☐ Ulcer	☐ Mental Illness: _____
☐ Other: _____	☐ Other: _____	☐ Other: _____

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Patient Name_____ Birth Date_____

HEALTH MAINTENANCE HISTORY

Please list the date of your last maintenance procedures and check whether it was abnormal or normal:

Colonoscopy: _____ ☐ Abnormal ☐ Normal	Physical Exam: _____ ☐ Abnormal ☐ Normal
Dental Visit: _____ ☐ Abnormal ☐ Normal	Eye Exam: _____ ☐ Abnormal ☐ Normal
Diabetic Eye Exam: _____ ☐ Abnormal ☐ Normal	Chest X-ray: _____ ☐ Abnormal ☐ Normal
EKG: _____ ☐ Abnormal ☐ Normal	Mammogram: _____ ☐ Abnormal ☐ Normal
Prostate Exam: _____ ☐ Abnormal ☐ Normal	Dexa Scan: _____ ☐ Abnormal ☐ Normal

SURGICAL HISTORY

Please list any surgeries you have had including the year and month:

Surgeries	Month	Year	Frequency

FAMILY HISTORY

Please list your Family History

	If Living	If Living or Deceased	If Deceased	If Deceased
	Age (s)	Health & Psychiatric	Age(s) at Death	Cause
Father				
Mother				
Maternal Grandfather				
Maternal Grandmother				
Paternal Grandfather				
Paternal Grandmother				
Brother				
Sister				
Daughter				
Son				

Hoover Family Medicine

PATIENT REGISTRATION FORM

Patient Name_____ Birth Date_____

OTHER PROVIDERS

Please list any other providers you are currently seeing:

Provider Name:	**Specialty:**
Provider Name:	**Specialty:**
Provider Name:	**Specialty:**

WOMEN'S HEALTH

Please provide the date of your most recent pap smear and answer the questions below:

Last Pap Smear: _____ ☐ Abnormal ☐ Normal		**Birth control method:**
Total # of pregnancies:	**Living children:**	**Miscarriages:**
Abortions:		

IMMUNIZATIONS

Please provide the most recent date of each immunization you have received below:

Hepatitis B: _____	**Pneumococcal: _____**	**Influenza B: _____**
Tetanus Booster: _____	**Zoster: _____**	**Tuberculosis: _____**
COVID – 19: _____		

SOCIAL HISTORY

Please answer all questions below:

Marital Status:	**Sexually Active: ☐ YES ☐ NO**	**How many children do you have?**
Employment: ☐ Disabled ☐ Full-time ☐ Part-time ☐ Retired ☐ Student ☐ Unemployed		
Occupation:	**Religious Beliefs:**	**Are you an organ donor? ☐ YES ☐ NO**
Do you use Alcohol? ☐ YES ☐ NO If yes, how many drinks do you have per week?		
Do you currently smoke Tobacco? ☐ YES ☐ NO If yes, how many cig/day? Starting age?		
Did you smoke tobacco in the past? ☐ YES ☐ NO How long? When did you quit?		
Do you use caffeine? ☐ YES ☐ NO If yes, how much/week?		**Are you dieting? ☐ YES ☐ NO**
Do you exercise? ☐ YES ☐ NO How many times/week? What type?		
Do you use recreational or street drugs? ☐ YES ☐ NO - If yes, what type?		

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SCREENING FOR DEPRESSION

Name:	Date of Birth:	Date:

Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not At All	Several Days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	☐	☐	☐	☐
2. Feeling down, depressed or hopeless	☐	☐	☐	☐
3. Trouble falling or staying asleep or sleeping too much	☐	☐	☐	☐
4. Feeling tired or having little energy	☐	☐	☐	☐
5. Poor appetite or overeating	☐	☐	☐	☐
6. Feeling bad about yourself or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
7. Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	☐	☐	☐	☐
9. Thoughts that you would be better off dead, or of hurting yourself in some way	☐	☐	☐	☐

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

FOR OFFICE USE ONLY:

SCORING:

Not At All: # marked ___ * 0 = 0
Several Days: # marked ___ * 1 = ___
More than half the days: # marked ___ * 2 = ___
Nearly every day: # marked ___ * 3 = ___

ADD 4 SCORES TO GET TOTAL SCORE: ___ / 27

☐ Provider assessment: No further evaluation needed.

☐ Referral: _____

Provider's Signature _____

Hoover Family Medicine

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CAGE-AID Questionnaire

Patient Name: _____ Date of Birth: _____ Date: _____

When thinking about drug use, include illegal drug use and the use of prescription drugs other than prescribed.

Questions:	**YES**	**NO**
Within the last year:		
1. Have you ever felt that you ought to cut down on your drinking or drug use?	☐	☐
2. Have people annoyed you by criticizing your drinking or drug use?	☐	☐
3. Have you ever felt bad or guilty about your drinking or drug use?	☐	☐
4. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover?	☐	☐
5. Have you ever been or are you currently being treated for alcohol or drug addiction? ___ years ago / ☐ Current	☐	☐

Comments: _____

_____

_____

_____

Hoover Family Medicine

NOTICE OF PRIVACY PRACTICES

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

This Notice of Privacy Practices is being provided to you as a requirement of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This notice describes how Hoover Family Medicine (HFM) may use and disclose medical information about you to carry out treatment, payment for our health care services and for other health care operations or purposes that are permitted or required by law. It also describes your rights to access and control medical information about you. As a patient of HFM, one of the responsibilities you have entrusted to us is the protection of your personal medical information. **Our physicians and staff take this responsibility very seriously.**

The uses and disclosures listed below may be limited by Alabama Requirements described under Regulatory Requirements.

Uses and Disclosures of Protected Health Information (PHI) for Treatment, Payment and Health Care Operations

The following describes the different ways that we (HFM) may use and disclose your PHI for treatment, payment and health care operations.

For Treatment – We may use PHI about you to provide you with medical treatment or services. For example, we may disclose your PHI to doctors, nurses, technicians, training doctors, or other health care professionals who are involved in taking care of you.
For Payment – We may use and disclose PHI about you so that the treatment and services you receive may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may disclose your PHI to your insurance company so that they will pay for our services rendered to you.
For Healthcare Operations – We may use and disclose your PHI for health care operations. Some of these operations include the use or disclosure of your PHI for quality improvement, doctor/employee review activities, compliance, and the training of medical residents and other health care professionals, which includes preceptorships for health care affiliates. For example, we may compare the treatment you received to other similar episodes of care to ensure that HFM continues to provide the highest quality services.

Business Associates

We may disclose PHI to "business associates", who perform services on behalf of our practice. Some examples of our business associates are transcription services, collection agency, and call answering service. Whenever an arrangement between our Practice and a business associate involves the use or disclosure of your PHI, we will have a written contract with that business associate that will protect your privacy.

Uses and Disclosure of Protected Health Information (PHI) Based upon Your Written Authorization

Other uses and disclosures of PHI not covered by this notice or the laws that apply to our Practice (described below) will be made only with your written permission. If you provide us permission to use or disclose your PHI, you may revoke that permission, in writing, at any time. If you revoke your permission, thereafter we will no longer use or disclose PHI about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission.

Uses and Disclosures That May Be Made With Your Agreement or Opportunity to Object

Unless you object, we may disclose some of your PHI to a family member, other relative, friend, or other persons you identify. We may also notify these people about your location and condition. When you are unable to agree or object, we may still disclose your PHI for these purposes in certain circumstances.

Other Permitted and Required Uses and Disclosure That May Be Made Without Your Authorization

In addition to using and disclosing your PHI for treatment, payment and health care operations, we may use or disclose your PHI without your written authorization in the following situations:

- As required by law: We may use or disclose your PHI when required to do so by applicable law. For example, in certain circumstances, we may also disclose PHI to report about an individual that we reasonably believe to be a victim of abuse, neglect, or domestic violence.
- For public health purposes.
- For health oversight activities authorized by law: We may disclose your PHI to the government for oversight activities, such as audits, I investigations, inspections, licensure and disciplinary actions, and other activities necessary for monitoring the health care system.
- For Workers' Compensation claims. (These programs provide benefits for work-related injuries or illnesses.)
- To a coroner, medical examiner or funeral director for the purpose of identifying a decedent, determining a cause of death, or as necessary to enable such parties to carry out their duties.
- For cadaveric organ, eye or tissue donations.
- For medical research purposes.
- To prevent or lessen a serious and imminent threat to the health or safety of a person or the public.
- For specialized government functions: In certain circumstances, we may use and disclose your PHI if you are a veteran or in the military. We may also disclose your PHI to authorized federal officials for intelligence and other national security activities, for the protection of the President or others, and for special investigations. If you are an inmate of a correctional institution or under custody of a law enforcement officer, we may disclose your PHI to the correctional facility or official in certain circumstances.

Continued on Page 2

I have read the above notice of privacy practices: ☐

Communication

We may use and disclose your PHI to contact you (by telephone or mail) and remind you of an appointment, or to inform you of treatment alternatives or other health-related benefits and services that may be of interest to you. We may be required to leave a message on your answering machine, when contacting you by telephone to remind you about an appointment, provide instructions prior to a diagnostic test or procedure, or to discuss payment. We may also use and disclose your PHI to encourage you to purchase or use a product or service through face-to-face communication or by giving you a promotional gift of nominal value.

Your Rights Regarding Medical Information About You Right to Inspect and Copy

You have the right to inspect and copy PHI that may be used to make decisions about your care. To inspect and copy PHI, you must submit your request in writing to our Privacy Officer. You will be notified when you record is ready to inspect or copies are completed. If you request a copy of the information, we will charge you a reasonable fee for the cost of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy in certain circumstances.

Right to Amend

If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have a right to request an amendment for as long as the information is kept. To request an amendment, your request must be made in writing to our Privacy Officer, and it must explain why you are requesting an amendment to your PHI. We may deny your request in certain circumstances. If this request is denied, HFM will send you a written letter supporting reason for denial.

Right to an Accounting of Disclosures

You have the right to request an "accounting of disclosure." This is a list of certain disclosures we have made of your PHI. You must submit your request in writing to our Privacy Officer. Your request must state a time period that may not be longer than six years and not include dates before April 14, 2003. The first list you request within a 12-month period will be free. For additional lists, we may charge you for the cost but we will notify you of this charge before it is incurred to you.

Right to Request Restrictions

You have the right to request a restriction or limitation on the PHI we use or disclose. 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. To request restrictions, you must make your request in writing to our Privacy Officer. 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. **Any previous restrictions given verbally or written to a HFM employee are no longer valid and must be requested in the above manner.**

Right to Request Confidential Communications

You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. To request confidential communications, you must make your request in writing to our Privacy Officer. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted. **Any previous requests given verbally or written to a HFM employee are no longer valid and must be requested in the above manner.**

Right to a Paper Copy of This Notice

Even if you agreed to receive this notice electronically, you have a right to request a paper copy by writing our Privacy Officer or asking for a copy at the reception/check-in desk at our HFM facility.

Regulatory Requirements

We are required by law to maintain the privacy of your medical information, and we must abide by the terms of this notice. (That is, the version that is currently in effect). We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for the medical information we already have about you, as well as any information we receive in the future. We will post a copy of the current notice, with the effective date listed in the bottom right hand corner of the last page. In addition to the privacy protections provided under federal law (which are described in this notice), Alabama law (referred to in this notice as the Alabama Requirements) requires us in certain situations to get your written consent (or, under some statutes or rules, written consent from your attorney, guardian, or upon court order) before we can use or disclose your information.
The Alabama Requirements may apply:

- If you qualify as a patient that suffers from a sexually transmitted disease;
- If you qualify as a patient that receives benefits from the State of Alabama for certain developmental disabilities or mental retardation;
- If you qualify as a patient that the Alabama Medicaid program has asked us to serve as a Case Management Service Provider for;
- If you qualify as a patient that receives rehabilitative services through the Alabama Medicaid program;
- If you qualify as a patient that receives certain benefits under the Alabama Medicaid's Preventive Health Education program.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services (or his or her designee). To file a complaint with HFM, contact our Privacy Officer at the address below. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

If you have any questions about HFM's Notice of Privacy Practices, please contact the Privacy Officer listed below.
Privacy Officer
3081 Lorna Road, Suite 101
Birmingham, AL 35216
Facsimile: (205) 979-3726
Effective date: April 14, 2003

I have read the above notice of privacy practices: ☐