EMORY HEALTHCARE

EMORY UNIVERSITY HOSPITAL
THE EMORY CLINIC
EMORY CRAWFORD LONG HOSPITAL
EMORY CHILDREN'S CENTER
WESLEY WOODS GERIATRIC HOSPITAL
BUDD TERRACE
DIALYSIS ACCESS CENTER OF ATLANTA
EMORY MEDICAL AFFILIATES

Admission/Registration Agreement

USE THIS AREA FOR STAMP OR LABEL WITH PATIENT INFORMATION

I. CONSENT FOR TREATMENT: I consent to such routine diagnostic and treatment procedures/examinations and laboratory procedures considered reasonably necessary for the care and treatment of my condition during my admission to an Emory Healthcare Hospital or my outpatient care at an Emory Healthcare facility. I understand that diagnostic and treatment procedures involving material risks will be explained to me and that I will have the opportunity to ask questions concerning the associated risks, alternatives and prognosis before allowing the procedures to be performed. I understand that Emory Healthcare's mission includes training physicians and other medical personnel and conducting medical research. I acknowledge that students may participate in my care. If I am asked to participate in a research study, I may refuse to participate and my refusal will not affect or compromise my access to medical services.

II. INDEPENDENT CONTRACTORS: I understand that some of the health care professionals providing care, treatment and services at the Emory Healthcare Hospitals or facilities are independent contractors, and are not agents or employees of the Hospitals or Emory Healthcare. Independent contractors are responsible for their own actions and neither the Hospitals nor Emory Healthcare shall be liable for the acts or omissions of any such independent contractors.

III. ASSIGNMENT OF BENEFITS/FINANCIAL AGREEMENT AND APPOINTMENT OF REPRESENTATIVE: If I am entitled to benefits under the Medicare program, the Medicaid program, or any insurance policy or other health benefit plan (covering me or anyone legally responsible for me), in consideration for admission to and for services provided to me by an Emory Healthcare facility, I assign, transfer and convey the benefits payable under such program, policy or plan for services rendered during my admission to the Emory Healthcare facilities that provide services to me. I authorize payment of benefits directly to such Emory Healthcare facilities, with such benefits to be applied to my bill. **I understand and acknowledge that this assignment does not relieve me of financial responsibility for charges incurred by me or anyone on my behalf, and I hereby acknowledge responsibility for and agree to pay charges not paid under this assignment, including any coinsurance amounts and deductibles and any charges for services deemed to be non-covered, not precertified or not preauthorized by my insurance plan.**

If my health care benefits are provided under a self-funded plan under the Employee Retirement Income Security Act - (ERISA), in order to assist me in obtaining my benefits: I authorize and appoint Emory Healthcare to act as my representative, when Emory Healthcare consents in writing to so act, in appealing any adverse benefit determination and to receive notices on my behalf with respect to same. I agree that I will comply with procedures established by my benefit plan relating to this authorization, if any.

IV. PERSONAL VALUABLES: I understand that Emory Healthcare Hospitals and Budd Terrace maintain a safe for patient money and valuables and that neither the Hospitals nor Budd Terrace nor any Emory Healthcare facility shall be legally responsible for the loss of or damage to any money, jewelry, glasses, hearing aids, dentures, documents or other articles of value, unless deposited with Emory Healthcare staff for safekeeping.

V. CONSENT FOR DISCLOSURE OF INFORMATION: I understand the Emory Healthcare facilities are permitted to disclose protected health information about me for purposes of payment, my continued care or treatment, and healthcare operations. If my protected health information includes any records containing information related to the treatment of any infectious disease (including AIDS confidential information), drug or alcohol abuse and/or mental illness, I hereby consent to the disclosure of this information by the Emory Healthcare facilities only as reasonably necessary to accomplish the purposes described above, and I waive any privileges with regard to such disclosure. I understand this consent permits release of the identified information to any insurance company, healthcare plan or any other person or entity financially responsible for my treatment if necessary for purposes related to filing a claim for payment, or, if I am being evaluated for a transplant, for purposes of determining eligibility, and to my referring physician and any health care practitioner, nursing home, health care facility, ambulance service, home health agency, government or private agency which may provide medical, mental health, rehabilitation, social or related services to me during or upon my discharge or transfer from an Emory Healthcare facility.

I understand my consent to disclosure of information related to treatment of any infectious disease (including AIDS confidential information), drug or alcohol abuse, or mental illness is valid until all bills related to my treatment have been paid and utilization and/or quality assessment have been completed. I further understand I can withdraw my consent for disclosure of such information at any time except to the extent action has been taken in reliance upon such consent.

VI. **AGREEMENT TO ALTERNATIVE DISPUTE RESOLUTION:** I agree that any claim or dispute arising out of or related to the provision of health care services to me by Emory University, Inc. d/b/a Emory University Hospital and Emory Crawford Long Hospital; The Emory Clinic, Inc.(and the Ambulatory Surgery Center); Emory Healthcare, Inc.; Emory Children's Center, Inc.; Wesley Woods Center of Emory University, Inc., or their employees or agents ("Emory"), except as otherwise provided herein, shall be resolved by final and binding arbitration. I agree that this provision is governed by the terms of the Federal Arbitration Act. I understand and agree that this agreement includes and encompasses any claims arising out of or relating to health care services which shall be provided to me upon this admission as well as all health care services provided to me by Emory in the future, provided, however, that this agreement does not include and encompass any claim or dispute by either party arising out of or related to the billing or payment for health care services. I understand and agree that by agreeing to arbitrate, I am waiving my right to a jury trial (if otherwise available). I understand that this agreement is also binding on any individual or entity claiming by or through me or on my behalf. I understand that this agreement is voluntary and is not a precondition to receiving health care services. The arbitration of any claim or dispute hereunder shall be conducted in the State of Georgia in accordance with the Rules and Procedures of Henning Arbitration and Mediation Services, Inc., a copy of which is available to me upon request . I understand that I have the right to revoke this agreement no later than ten (10) days following signature and that, if I choose to revoke, I must request and execute a revocation form within this time period.

NOTE: If the individual signing this agreement is doing so on behalf of his or her minor child or any other person for whom he or she is legally responsible, the signature below affirms that he or she has the authority or obligation to contract with Emory for the provision of health care services to that minor child or other person, and that his or her execution of this agreement is in furtherance of that authority or obligation.

DATE:____________________ ____

PATIENT, PARENT, GUARDIAN OR AUTHORIZED REPRESENTATIVE

VII. **PHOTOGRAPHS, VIDEOTAPES, AND RECORDINGS:** I understand that the physicians or staff at certain of the Emory Healthcare facilities may request to take photographs, videotapes or other recordings of me for purposes of ensuring proper patient identification or for medical documentation, care or treatment purposes, and I consent to being photographed, videotaped, or recorded for these purposes. I further acknowledge that such photographs, videotapes, recordings, and related information may be used for internal operations purposes of Emory Healthcare, including, but not limited to medical education, training programs, quality assessment and improvement activities, outcomes evaluation, case management, and related functions that do not include treatment. I understand that such photographs, videotapes and recordings will be maintained in a secure manner and will not be disclosed for external use, except upon written authorization from me or my authorized representative or as required or permitted by law.

VIII. **HOSPITAL PATIENT DIRECTORY:** If I am a hospital patient, I understand the following information will be included in the Hospital Directory – my Name, my Room Number/Location, my General Condition such as Fair, Stable or Critical, and my Religious Affiliation (if expressed). I understand that my location in the hospital and my general condition will be provided to persons who inquire about me by name, and that my religious affiliation along with the other directory information will be provided to members of the clergy who request information on patients based on their religious affiliation. Patients in an Emory Healthcare Mental Health Unit are not included in the Hospital Directory.

If you are a hospital patient and do not want your information included in the Hospital Directory, please check Opt-Out of Hospital Directory below and initial.

- I Opt Out of the Hospital Directory ____________ *(please initial)*

IX. **ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

I have received the Emory Healthcare Notice of Privacy Practices. _________ *(please initial)*

The date of this Admission Agreement is (insert today's date) ______________________

______________________ ______________________________________

Witness Signature of Patient or Patient's Representative

____

Relationship of Representative to Patient

THE EMORY CLINIC, INC.

PLEASE PRINT OR TYPE

PRE-REGISTRATION INFORMATION

For Office Use Only:

Medical Record Number:
Appointment Date/ Time:
Emory Clinic Physician:

Have you ever been treated at the Emory Clinic, Emory Univ. Hospital, Crawford Long or Egleston?________

PATIENT INFORMATION:

PATIENT NAME LAST FIRST MIDDLE	SOCIAL SECURITY NUMBER	DATE OF BIRTH	SEX
MAIDEN NAME LAST FIRST MIDDLE	EMPLOYER		MARITAL STATUS
STREET APT	OCCUPATION		
CITY STATE ZIP	STREET CITY		
HOME PHONE: ( ) / BUSINESS /DAYTIME PHONE: ( ) EXT	CELL PHONE: ( )	STATE ZIP	
E-MAIL ADDRESS			

PERSON RESPONSIBLE FOR BILL (OMIT IF SAME AS PATIENT INFORMATION):

LAST FIRST MIDDLE	RELATIONSHIP	SOCIAL SECURITY NO.	D.O.B.
STREET APT	EMPLOYER	OCCUPATION	
CITY STATE ZIP	STREET		
HOME PHONE: ( ) / BUSINESS/ DAYTIME PHONE: ( )	CITY STATE ZIP		

EMERGENCY CONTACT - IF RESIDING AT A DIFFERENT ADDRESS (e.g., Friend or Relative):

LAST FIRST MIDDLE	RELATIONSHIP
STREET APT	HOME PHONE: ( )
CITY STATE ZIP	BUSINESS/ DAYTIME PHONE: ( )

REFERRING PHYSICIAN

LAST FIRST MIDDLE	PHONE: ( )
STREET CITY STATE ZIP	

PRIMARY CARE PHYSICIAN

LAST FIRST MIDDLE	PHONE: ( )
STREET CITY STATE ZIP	

PLEASE COMPLETE REVERSE SIDE

- OVER -

30-0262-01

FINANCIAL INFORMATION

PLEASE BRING INSURANCE CARDS, REFERRAL FORMS (HMOs, POSs, PPOs), OR AUTHORIZATION TO BILL WORKMAN'S COMPENSATION OR OTHER THIRD PARTY PAYOR.

PRIMARY INSURANCE:

PRIMARY INSURANCE CARRIER NAME		POLICY#	GROUP#	COPAY	PLAN TYPE(HMO/PPO)
ADDRESS TO MAIL CLAIMS		SUBSCRIBER'S NAME/ DATE OF BIRTH		VERIF. OF BENEFITS PHONE	
CITY STATE ZIP		SUBSCRIBER'S SOCIAL SECURITY NUMBER		PRECERTIFICATION PHONE	
BEGINNING DATE:	REFERRAL NO. (IF APPLICABLE)	PRECERTIFICATION NUMBER (IF APPLICABLE)		PRIMARY CARE PHYSICIAN	

SECONDARY INSURANCE:

PRIMARY INSURANCE CARRIER NAME		POLICY#	GROUP#	COPAY	PLAN TYPE(HMO/PPO)
ADDRESS TO MAIL CLAIMS		SUBSCRIBER'S NAME/ DATE OF BIRTH		VERIF. OF BENEFITS PHONE	
CITY STATE ZIP		SUBSCRIBER'S SOCIAL SECURITY NUMBER		PRECERTIFICATION PHONE	
BEGINNING DATE:	REFERRAL NO. (IF APPLICABLE)	PRECERTIFICATION NUMBER (IF APPLICABLE)		PRIMARY CARE PHYSICIAN	

IS THIS VISIT DUE TO A WORK RELATED CONDITION?__________

WILL YOU BE USING WORKER'S COMPENSATION INSURANCE?__________

EMPLOYER	WORK COMP INSURANCE COMPANY NAME	ADJUSTOR NAME	
STREET	STREET	DATE/ DESCRIPTION OF INJURY	
CITY STATE ZIP	CITY STATE	ZIP	W/C POLICY NO.
PHONE TO VERIFY W/C ( )	W/C INSURANCE PHONE ( )		CLAIM NO.

1. FINANCIAL AGREEMENT

I hereby assume full responsibility for all charges incurred for professional services rendered by Emory Clinic physicians,unless the services are deemed "paid in full" as a result of a contractual agreement between The Emory Clinic and my insurer.

2. AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize The Emory Clinic to release any medical, psychiatric, infectious disease (including AIDS confidential information) or drug and/or alcohol related information to my referring physician and any insurance company with whom I have medical benefits for the purpose of filing a medical claim. I acknowledge that this authorization is valid until such time as all medical bills related to my treatment have been paid. I further understand that I can withdraw this consent for release of information at any time prior to this expiration date except to the extent that action has been taken in reliance hereon.

3. GROUP & INDIVIDUAL INSURANCE, ASSIGNMENT OF BENEFITS

I authorize my health insurance benefit plan to pay directly to The Emory Clinic, the surgical and/or medical benefits. If any, otherwise payable to me for their services as described on attached claim but not to exceed the charges for those services. I understand I am financially responsible to the Clinic for charges not covered by this agreement.

4. MEDICARE, CLAIM AUTHORIZATION AND PAYMENT REQUEST

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to Medicare assigment of benefits apply.

Signature:______________________________________ **Date:** ______________

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU MAY GAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) directs health care providers, payers, and other health care entities to develop policies and procedures to ensure the security, integrity, privacy and authenticity of health information, and to safeguard access to and disclosure of health information. The federal government has privacy rules which require that we provide you with information on how we might use or disclose your identifiable health information. We are required by the federal government to give you our **Notice of Privacy Practices.**

OUR COMMITMENT TO YOUR PRIVACY

As a healthcare provider, we use your confidential health information and create records regarding that health information in order to provide you with quality care and to comply with certain legal requirements. We understand that this health information is personal, and we are dedicated to maintaining your privacy rights under Federal and State law. This Notice applies to records of your care created or maintained by EMORY HEALTHCARE.

We are required by law to: (1) make sure we have reasonable processes in place to keep your health information private; (2) give you this Notice of our legal duties and privacy practices with respect to your health information; and (3) follow the terms of the Notice that are currently in effect.

WHO WILL FOLLOW THIS NOTICE

Emory University and EMORY HEALTHCARE facilities that will abide by this notice include, but are not limited to, Emory University Hospital, Emory University Hospital Midtown, The Emory Clinic, Clark Holder Clinic, Emory Speciality Associates, Emory Children's Center, Wesley Woods Geriatric Hospital (including the Wesley Woods Outpatient Clinic, and Long Term Hospital), Budd Terrace and Dialysis Access Center of Atlanta, and Emory Dialysis Centers collectively referred to as EMORY HEALTHCARE.

EMORY HEALTHCARE facilities are part of an organized health care arrangement with other components of Emory University, such as the School of Medicine. On occasion, we may disclose health information with these components of the University if necessary to carry out treatment, payment of healthcare operations related to the organized health care arrangement. All components of the organized health care arrangement are required to abide by the confidentiality obligations in this Notice.

HOW WE MAY USE OR DISCLOSE YOUR HEALTH INFORMATION WITHOUT YOUR AUTHORIZATION

The following information describes different ways that we may use or disclose your health information without your authorization. Although we cannot list every use or disclosure within a category, we are only permitted to use or disclose your health information without your authorization if it falls within one of these categories.

If your health information contains information regarding your mental health or substance abuse treatment or certain infectious diseases (including HIV/AIDS tests or results), we are required by state and federal confidentiality laws to obtain your consent prior to certain disclosures of the information. Once we have obtained your consent of the Admission/Registration Agreement, we will treat the disclosure of such information in accordance with our privacy practices outlined in this Notice.

CATEGORIES FOR USES AND DISCLOSURES:

Treatment. We may use health information about you to provide you with medical treatment or services. We may disclose health information about you to doctors, nurses, technicians, medical students, residents, student nurses, or other healthcare personnel who are involved in taking care of you at EMORY HEALTHCARE or at another healthcare provider. 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 within EMORY HEALTHCARE also may share health information about you in order to coordinate the different things you need, such as prescriptions, lab work and x-rays.

Payment. We may use or disclose health information about you in order to bill and collect payment for the services and items you may receive from us. For example, we may need to give your health insurance plan information about your surgery so your health insurance plan will pay us or reimburse you for the surgery. We may also tell your health insurance plan about a treatment you are going to receive in order to obtain prior approval or to determine whether your health insurance plan will cover the treatment. We may disclose to other healthcare providers health information about you for their payment activities.

Health Care Operations. We may use and disclose health information about you for EMORY HEALTHCARE operations. For example, we may use health information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine health information about our patients to decide what additional services should be offered, what services are not needed, and whether certain new treatments are effective. We may disclose your health information to doctors, nurses, technicians, medical students, residents, nursing staff and other personnel for review and learning purposes. We may combine the health information we have with health information from other healthcare providers to compare how we are doing and see where we can make improvements in the care and services we offer.

Medical Staff Members. EMORY HEALTHCARE and the independent physicians and other health care providers who are members of an EMORY HEALTHCARE facility's medical staff are considered to be an organized healthcare arrangement under federal law for the specific purpose of sharing patient information. As such, EMORY HEALTHCARE and its medical staff will share health information about

patients necessary to carry out treatment, payment and health care operations. Although all independent medical staff members who provide care at EMORY HEALTHCARE follow the privacy practices described in this Notice, they exercise their own independent medical judgement in caring for patients and they are solely responsible for their own compliance with the privacy laws. EMORY HEALTHCARE and independent medical staff members remain completely separate and independent entities that are legally responsible for their own actions.

Appointment Reminders, Follow-up Calls and Treatment Alternatives. We may use or disclose health information to remind you that you have an appointment or to check on you after you have received treatment. If you have an answering machine we may leave a message. We also may send you a post card appointment reminder. We may contact you about possible treatment options or alternatives or other health related benefits or services that may be of interest to you.

Fundraising Activities. We may use health information to contact you for fundraising needs. We would only use contact information, such as your name, address and phone number and the dates you received treatment or services. If you do not want EMORY HEALTHCARE to contact you for fundraising efforts, you must put the request in writing and send to The Woodruff Health Sciences Center, 1440 Clifton Road, Suite 116, Atlanta, Georgia 30322.

EMORY HEALTHCARE Directory. We may use or disclose health information about you in the patient directory while you are a patient at an EMORY HEALTHCARE facility. This information may include your name, location in the facility, your general condition (e.g., fair, stable, etc.) and your religious affiliation. The directory information, except for your religious affiliation, may 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. You will be given the option not be listed in the directory. If you choose not to be listed in the directory, we will not be able to tell any family or friends that you are in the facility, nor will we be able to tell flower couriers where you are located.

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

Records Research. We may use or disclose health information under certain circumstances for medical research purposes. For example, a research project may compare the health of patients who received one medication to those who received another for the same condition. We will obtain your written authorization to use or disclose your health information for research purposes **except when** (a) an Institutional Review Board (IRB) determines in advance that use or disclosure of your health information meets specific criteria required by law; or; (b) the researcher signs a legally binding document certifying that he/she will only use the health information to prepare a research protocol or for similar purposes to prepare for a research project and that he/she will maintain the confidentiality of the information and will not remove any of the health information from EMORY HEALTHCARE. EMORY HEALTHCARE may also disclose health information to a researcher if it involves health information of deceased patients and the researcher certifies the information is necessary for research purposes.

Clinical Research. If you are enrolled in a clinical research trial through a School or Department of Emory University and you would like information on the Emory University privacy policies regarding use and disclosure of your health information related to the clinical trial, you may request information from the Emory University Privacy Officer, 1599 Clifton Road, N.E., Suite 4-105, Atlanta, Georgia 30322.

As Required By Law. We will use or disclose 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 or disclose health information when necessary to prevent a serious threat to your health and safety, or the health and safety of another person or the public. Any disclosure, however, would only be to someone able to help prevent the threat.

SPECIAL SITUATIONS

We may also use or disclose your health information without your authorization in the following situations:

Organ and Tissue Donation. To organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans. To military command authorities as required, if you are a member of the armed forces. We may also disclose health information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation. To workers' compensation or similar programs that provide benefits for work-related injuries or illness.

Public Health Activities. To public health agencies or other governmental authorities to report public health activities or risks. These activities generally include the following: to prevent or control disease, injury or disability; to report births and deaths; 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 as authorized by law; to notify the appropriate government authority if we believe 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. 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 the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. In response to a court or administrative order, if you are involved in a lawsuit or a dispute. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the health information requested.

Law Enforcement. In response to a court order, subpoena, warrant, summons or similar process; or upon request by a law enforcement official to identify or locate a suspect, fugitive, material witness, or missing person or to obtain information about the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's authorization. We may report a death we believe may be the result of criminal conduct or report suspected criminal conduct occurring on the premises. We may also report information related to a suspected crime discovered in the course of providing emergency medical services.

Coroners, Medical Examiners and Funeral Directors. To a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release health information about patients of EMORY HEALTHCARE to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities. To authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.

Protective Services for the President and Others. To authorized federal officials so they may provide protection to the President of the United States, other authorized persons or foreign heads of state or to conduct special investigations.

Inmates. To the correctional institute or law enforcement official, if you are an inmate of a correctional institution or under the custody of a law enforcement official. This release would be necessary (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 of the correctional institution.

USES AND DISCLOSURES WHICH REQUIRE YOUR AUTHORIZATION

Other types of uses and disclosures of your health information not described in this Notice will be made only with your written authorization. You may revoke your authorization by giving written notice to the medical records department where you received your care. Please see the list of addresses at the end of this Notice. If you revoke your authorization we will no longer use or disclose your health information as permitted by your initial authorization. Please understand that we will not be able to take back any disclosures we have already made and that we are still required to retain our records containing your health information that documents the care that we provided to you.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

Right to Inspect and Copy. You have the right to inspect and obtain a copy of your medical record or billing record.

To inspect and copy your medical or billing record, you must submit your request in writing to the Medical Records Department where you received your care. You need to include in your request your name or if acting as a personal representative include the name of the patient, contact information, date of birth and dates of service if known. Please see the list of addresses at the end of this notice. If you request a copy, you will be charged a fee for the costs of copying, mailing or other supplies associated with your request.

We may deny your request to inspect and copy records in certain limited circumstances; however, you may request that the denial be reviewed. A licensed health care professional chosen by EMORY HEALTHCARE will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Request an Amendment. If you feel that health information we have about you is incorrect, you may ask us to amend it. You have the right to request an amendment for as long as the health information is kept by or for EMORY HEALTHCARE.

To request an amendment, your request must be made in writing and submitted to The Medical Record Department of the entity where you received your care. In addition, you must provide a reason that supports your request. You need to include in your request your name, contact information, date of birth and dates of service if known. If you are acting as a personal representative include the name of the patient, your contact information, date of birth and dates of service if known.

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 to amend health information that:

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

Right to an Accounting of Disclosures. You have the right to request a list of the disclosures we made of your health information except for disclosures:

- for treatment, payment or healthcare operations,
- pursuant to an authorization,
- incident to a permitted use or disclosure, or
- certain other limited disclosures defined by law.

To request this list of disclosures, you must submit your request in writing to the EMORY HEALTHCARE Privacy Office at 101 West Ponce de Leon Ave, Suite 610, Decatur, Georgia 30030. Your request must specify a time period for which you are seeking an accounting of disclosures and include your name, contact information, date of birth and dates of service if known. If you are acting as a personal representative include the name of the patient, your contact information, date of birth and dates of service if known.

You may not request disclosures that are more than six years from the date of your request or that were before April 14, 2003. Your request should indicate in what form you want the list, for example, on paper or electronically. The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

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 information about a surgery you had.

Except as otherwise required by law, we will comply with a request to restrict disclosure of health information to a health plan for purposes of carrying out payment or healthcare operations, BUT ONLY if the health information you ask to be restricted from disclosure pertains solely to a health care item or service for which you have paid out of pocket, in full.

We are not required to agree to any other requests. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment. We have the right to revoke our agreement at any time, and once we notify you of this revocation, we may use or disclose your health information without regard to any restriction or limitation you may have requested.

To request restrictions, you must make your request in writing to EMORY HEALTHCARE Privacy Office, 101 West Ponce de Leon Ave. Suite 610, Decatur, Georgia 30030. 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 medical 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 EMORY HEALTHCARE Privacy Office, 101 West Ponce de Leon Avenue, Suite 610, Decatur, Georgia 30030. You will need to include your name or if acting as a personal representative include the name of the patient, contact information, date of birth and dates of service if known.

We will not ask you the reason for your request. We will work to accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right To Receive a Paper Copy of This Notice. Even if you have agreed to receive this Notice electronically, you have the right to receive a paper copy of this Notice, which you may ask for at any time.

You may obtain a copy of this Notice at our website, www.emoryhealthcare.org.

To obtain a paper copy of this Notice, write to EMORY HEALTHCARE Privacy Office, 101 West Ponce de Leon Avenue, Suite 610, Decatur, Georgia 30030.

ADDITIONAL INFORMATION: We have put in place reasonable processes and procedures to protect the privacy and security of your health information. If there is an unauthorized acquisition, access, use, or disclosure of your protected health information we will disclose this to you as required by law. The law may not require notice to you in all cases.

CHANGES TO THIS NOTICE

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for health information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice at the EMORY HEALTHCARE facilities and you may request a copy of the current notice. In addition, the current notice will be posted at www.emoryhealthcare.org.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint by writing to: Chief Privacy Officer, EMORY HEALTHCARE, 101 W. Ponce de Leon Avenue, Suite 610, Decatur, GA 30030. You may also file a complaint with the Secretary of the Department of Health and Human Services. **You will not be penalized for filing a complaint.**

For further information you may send written inquiries to the EMORY HEALTHCARE Privacy Office, 101 West Ponce de Leon Avenue, Suite 610, Decatur, GA 30030 or call 404-778-2757.

Additional Important Addresses:

1. The Emory Clinic – Medical Records Department, 1550 Litton Drive, Stone Mountain, Georgia 30083
2. Emory University Hospital – Medical Records Department, 1364 Clifton Rd, Atlanta, Georgia 30322
3. Emory University Hospital Midtown – Medical Records Department, 550 Peachtree Street, Atlanta, Georgia 30308
4. Emory Children's Center – Medical Records Department, 1405 Clifton Road, N.E., Atlanta, GA 30322
5. Wesley Woods Geriatric Hospital – Medical Records, 1821 Clifton Road, N.E., Atlanta, GA 30329
6. Wesley Woods Outpatient Clinic, Wesley Woods Long Term Hospital or Budd Terrace – Medical Records Department, 1833 Clifton Road, N.E., Atlanta, GA 30329
7. Dialysis Access Center of Atlanta, 552 Ponce de Leon Ave., Atlanta, GA 30308
8. Emory Clark-Holder Clinic, 303 Smith Street, LaGrange, GA 30240

3/18/03

Revised 6/16/04

Child and Adolescent Mood Program

1256 Briarcliff Rd.
Atlanta, GA 30306
phone 404.727.3443 fax 404.727.3421

New Patient History: Today's Date: ___/___/____

Name ______________________ Date of Birth ___/___/_____ Age ________

Gender: ☐ M ☐ F Patient's Race/Ethnicity ________________

Occupation ____________________ County: __________________________

Grade in School: ______ Patient's School (*note if home schooled*): ____________________

Numbers (H): ______________ (C): ______________ Other: _______________

Reason for Visit ____

Minor Patient: Is the patient a minor? ☐ Yes ☐ No
If yes, please complete the following information regarding patient's primary caretaker(s) (e.g., parents, grandparents, aunts, uncles, foster parents, etc.).

	Caretaker 1	Caretaker 2
Name		
Relationship to Patient		
Address		
Phone #s		
Occupation		

What is the marital status of the patient's parents? ____________________________

With which caretaker(s) does the patient currently live? _______________________

Which caretaker(s) has legal rights for the patient? ___________________________

Please note any custodial or legal arrangements pertinent to the patient's medical care:

____

Patient's Current Psychiatric Status:

Is the patient currently seeing a psychiatrist and/or therapist? ☐ Yes ☐ No

Name: ____________________

Location: ____________________

How Long: ____________________

Name: ____________________

Location: ____________________

How Long: ____________________

Psychiatric History:

Previous Outpatient Psychiatric Treatment: Where and when? For what period of time?

____

____

____

____

Previous Psychiatric Hospitalizations: Where and when? For what period of time?

____

____

____

____

Does the patient have any history of suicide attempts or self injury? ☐ Yes ☐ No

If yes, please provide additional details below.

____

____

____

____

Does the patient have any history of violence or harm to others? ☐ Yes ☐ No

If yes, please provide additional details below.

____

____

____

____

MEDICATIONS: List **ALL** medications the patient takes regularly (include over the counter meds/herbal supplements).

1. ______________________ 4. ______________________
2. ______________________ 5. ______________________
3. ______________________ 6. ______________________

Please list any medications taken in the past 6 months that the patient is no longer taking:

____

Review of Symptoms: *Please place a check (√) by any symptoms experienced recently.*

__Sad Mood	__Suicidal Ideation	__Agoraphobia	__Irritability
__Tearfulness	__Homicidal Ideation	__Nightmares	__Hyperactive/Impulsive
__No Pleasure	__Low Self-esteem	__Flashbacks	__Confused Thinking
__No Energy	__Poor Concentration	__Obsessions	__Disorganization
__Sleep Disturbance	__Anxiety/Worry	__Compulsions	__Hallucinations
__Appetite Disturbance	__Panic Attacks	__Elation/Mania	__Delusions

FAMILY HISTORY

☐ *Please check if patient is adopted (if so, complete based on biological history if known)*

Mother: ☐ Living ☐ Deceased-Cause: Age:

Father: ☐ Living ☐ Deceased-Cause: Age:

Siblings: Number living _____ Number deceased _____

Cause(s) of death & age at death ______________________

HAVE ANY OF THE PATIENT'S RELATIVES BEEN DIAGNOSED WITH THE FOLLOWING?
Please circle all that apply:

ADD/ADHD	NONE	MOTHER	FATHER	SIBLING: BROTHER/SISTER	GRANDPARENT	OTHER	UNKNOWN
ALCOHOLISM/DRUG ABUSE	NONE	MOTHER	FATHER	SIBLING: BROTHER/SISTER	GRANDPARENT	OTHER	UNKNOWN
ANXIETY	NONE	MOTHER	FATHER	SIBLING: BROTHER/SISTER	GRANDPARENT	OTHER	UNKNOWN
BIPOLAR DISORDER	NONE	MOTHER	FATHER	SIBLING: BROTHER/SISTER	GRANDPARENT	OTHER	UNKNOWN
DEPRESSION	NONE	MOTHER	FATHER	SIBLING: BROTHER/SISTER	GRANDPARENT	OTHER	UNKNOWN
PANIC ATTACKS	NONE	MOTHER	FATHER	SIBLING: BROTHER/SISTER	GRANDPARENT	OTHER	UNKNOWN
POSTTRAUMATIC STRESS DISORDER	NONE	MOTHER	FATHER	SIBLING: BROTHER/SISTER	GRANDPARENT	OTHER	UNKNOWN
SCHIZOPHRENIA	NONE	MOTHER	FATHER	SIBLING: BROTHER/SISTER	GRANDPARENT	OTHER	UNKNOWN
SUICIDE ATTEMPT	NONE	MOTHER	FATHER	SIBLING: BROTHER/SISTER	GRANDPARENT	OTHER	UNKNOWN
VIOLENCE	NONE	MOTHER	FATHER	SIBLING: BROTHER/SISTER	GRANDPARENT	OTHER	UNKNOWN

CAMP CLINIC POLICIES

Please review each of the following policies and sign where indicated.

Cancellation & No-Show Policy
We respectfully request that you notify the clinic (404-727-3443) if you are unable to attend your appointment as scheduled. We greatly appreciate a minimum of 24 hours notice for regular or follow-up appointments and a minimum of 48 hours notice for first-time appointments or evaluations; however, any notice at all is appreciated.

If you discover that you have missed a scheduled appointment, please call us as soon as possible to reschedule. Please also note that patients who no-show for three (3) appointments in a six-month period may be referred to another clinic for treatment.

Signed:_________________________________ Date____/____/______

Prescription Refill Policy
In order for CAMP physicians to maintain the highest standard of care, it is of critical importance that you meet regularly with your psychiatrist to continue to receive your prescription refills in a timely manner. Talk with your psychiatrist about how often you are expected to return to the clinic for follow-up appointments. Most patients will need to plan to be seen at least once monthly unless otherwise indicated by your psychiatrist. Our general policy is to refill prescriptions no more than once between appointments. If you are unable to maintain regular appointments with your psychiatrist, we may not be able to continue to meet your medication management needs and we will help you seek treatment elsewhere. We strongly encourage you to schedule your follow-up appointments at the conclusion of your current appointment in order to ensure that you are seen in time for prescription renewal.

In the event that you need to renew a prescription between appointments, please allow three (3) business days for renewals by phone and five (5) business days for written renewals. Please note that we cannot mail written prescriptions – they must be picked up in person at the clinic during normal business hours. Prescriptions will only be dispensed to the patient or an authorized representative (i.e., a parent or another individual for whom the patient has signed a release of information). You will be asked to sign for all prescriptions picked up in the clinic.

Signed:_________________________________ Date____/____/______

Financial Responsibility
I understand that all professional services are charged to the patient and are due and payable on the date that services are rendered unless other arrangements have been made with the financial counselor, Carolyn Algarra. I agree to pay all such charges in full immediately upon services rendered.

Signed:_________________________________ Date____/____/______
Guarantor

Office use only

MRN: ______________________________ Co-Pay (or self pay): __________

Physician(s): ______________________________________

Filled out school excuse release? Yes Rx Policy, Notified on: ______/______/________

Patient Name: ________________ Date of Birth: ______/______/________

Insurance Company: ____

Legal Guardians

1. Name: ________________________________ Relationship: ________________

   Phone #s: (_______) _______-________ (h w c) OK to leave a message?: Yes No

   Phone #s: (_______) _______-________ (h w c) OK to leave a message?: Yes No

2. Name: ________________________________ Relationship: ________________

   Phone #s: (_______) _______-________ (h w c) OK to leave a message?: Yes No

   Phone #s: (_______) _______-________ (h w c) OK to leave a message?: Yes No

Preferred Contact #

Name: ________________________________ Relationship: ________________

Phone #s: (_______) _______-________ (h w c) OK to leave a message?: Yes No

Phone #s: (_______) _______-________ (h w c) OK to leave a message?: Yes No

People Authorized to Discuss Patient's Records (other than patient)

1. ______________________________ 3. ______________________________

2. ______________________________ 4. ______________________________

People Authorized to Pick Up Patient Prescriptions (other than patient)

1. ______________________________ 3. ______________________________

2. ______________________________ 4. ______________________________

____ ____________________

Patient Signature (or legal guardian) Date

Emory Child and Adolescent Mood Program
W. Edward Craighead, Ph.D., Director
Vivianne Aponte Rivera, M.D. ◆ Rosario Morillo Falero, M.D., Ph.D. ◆ Priya Jacob, M.D.
Cynthia Ramirez, Ph.D. ◆ Lorie Ritschel, Ph.D. ◆ Diana Simeonova, Ph.D. ◆ J. Steven Snow, Ph.D. ◆
Lindsay M. Stewart, Ph.D., ◆ Sasha Zagoloff, Ph.D.
1256 Briarcliff Rd. Suite 320E ◆ Atlanta, GA 30306
Phone: 404.727.3443 ◆ Fax: 404.727.3421

CONSENT TO COMMUNICATE VIA EMAIL

The staff at the Child and Adolescent Mood Program (CAMP) understands that email is a very common and convenient method of communication. It is, however, less secure and therefore less confidential than other methods of communication. In particular, privacy cannot be guaranteed for any correspondence using a work e-mail account, as your employer owns your computer and hard drive and may be able to access your messages. Because of this, CAMP discourages the use of email for confidential matters. While we understand that this method of communication may be preferable, some clinicians prefer not to communicate electronically. If you would like to communicate with your clinician via email, please discuss this option with your clinician and get his or her permission to do so. By signing below, you are indicating that you would like to use email to communicate with your clinician and/or the CAMP staff for non-clinical matters (e.g., scheduling) and that you understand the limits of email communication. Again, emailing for clinical purposes is strongly discouraged.

PLEASE SELECT ONE OPTION AND CHECK THE APPROPRIATE BOX:

☐ OPTION 1

I, ______________________________, understand that communication via email is not secure and may result in a breach of my confidentiality. I also acknowledge that any e-mail correspondence with my clinician will be included in my medical record. I do, however, consent to confidential communication via email with my clinician and/or the CAMP staff, and will only email my clinician if I have his or her permission.

Please write up to two email addresses you will use to communicate with CAMP:

(1) ______________________ (2) ______________________

☐ OPTION 2

I, ______________________________, do not want to be contacted via email, and I will not contact my clinician or the CAMP staff via email.

Patient Name: ______________________________

______________________________ Date:______________

Signature of Patient or Legal Representative

Emory Child and Adolescent Mood Program
A Part of the The Emory Clinic
W. Edward Craighead, Ph.D., Director
Carla Alvarez, Ph.D. • Vivianne Aponte Rivera, M.D. • Priya Jacob, M.D.
Cynthia Ramirez, Ph.D. • Lorie Ritschel, Ph.D. • Sheethal Reddy, Ph.D.
Diana Simeonova, Ph.D. • J. Steven Snow, Ph.D.
1256 Briarcliff Rd. Suite 320E
Atlanta, GA 30306
Phone: 404.727.3443 Fax: 404.727.3421

CONSENT TO VIDEOTAPE

I, ________________________, consent for the staff, employees, agents, or representatives of the Emory Child and Adolescent Mood Program (CAMP) to videotape record my child's individual or group therapy sessions and/or assessment sessions. I understand that the videotape recording may contain details about my child's current or past medical or mental health condition(s). I understand that these videotapes will be used to provide clinical care as well as for training purposes, including the teaching of students or practitioners who are learning or working to improve their skills in conducting individual or group psychotherapy.

I hereby waive any privilege that might otherwise apply to any information concerning my child captured in the videotape recording consent above, including any privilege(s) relating to treatment of physical or mental illness, chemical dependency or alcohol abuse, or testing or treatment of for any communicable or infectious disease, such as acquired immunodeficiency syndrome (AIDS), immunodeficiency Syndrome Related Complex (ARC), human immunodeficiency virus (HIV), venereal disease, tuberculosis (TB) or hepatitis.

I may revoke this consent in writing except to the extent any action has already been taken based on it. Revocation must be made in writing and sent to Dr. W. Edward Craighead, PhD at the above address.

I further understand that these videotapes will be kept in locked cabinets when not in use and that these tapes are the property of the Emory CAMP. Please note that we are not able to make copies of these videotapes for personal use.

______________________________ Date: ____________________
Patient Name (print)

____
Patient Signature

______________________________ Date: ____________________
Parent Name (print)

____
Parent Signature

______________________________ Date: ____________________
Witness Signature

Emory University School of Medicine
Department of Psychiatry and Behavioral Sciences
Information about the Study

Title: Evaluating Psychological Constructs of Interest in Treatment at the Emory Child and Adolescent Mood Program (CAMP)

Principal Investigator: Lorie A. Ritschel, PhD

Introduction:
You are being asked to take part in this research because you will be receiving treatment at the Child and Adolescent Mood Program (CAMP) and we wish to evaluate how psychological variables such as depression and anxiety relate to each other, and we also are interested in the effectiveness of treatment at CAMP. We expect to include all new patients who come to CAMP for treatment. Please read this form carefully and ask any questions you may have.

Purpose:
The scientific purpose of this study is to track patient variables and symptoms so that we know what kinds of problems people have and how symptoms change over time after treatment at CAMP.

Procedures:
We will analyze your answers to survey and interview questions that are given as part of your regular treatment. There are no research-related tests or procedures.

Risks and Discomforts:
There are some minimal risks associated with the loss of confidentiality as a participant in this study. These risks are minimized by de-identifying all patient data and keeping all information double locked and password-protected.

Benefits: This study is not designed to benefit you. However, while it may not help you personally, study doctors and researchers may learn new things that will help others.

Compensation:
No compensation will be given for your participation in the study.

Confidentiality:
Emory will keep any research records we produce private to the extent we are required to do so by law. A study number rather than your name will be used on study records. Your name and other facts that might point to you will not appear in our databases or when we present this study or publish its results.

Questions
If you have any general questions about this study, please call Chris Sheppard or John Cooley, the study coordinators. If you feel that you have been harmed by your participation in this study, please call Dr. Lorie Ritschel. If you have questions about your rights as a research subject or any concerns or complaints about the research, you may contact the Emory Institutional Review Board.
Chris Sheppard and John Cooley: 404-727-4799
Dr. Lorie Ritschel: 404-712-8291
IRB: 404-712-0720 or 877-503-9797 or irb@emory.edu.