EMORY HEALTHCARE

# REGISTRATION FORM

Welcome to our Rehabilitation Department. We would like for your experience to be an enjoyable one. Your physician has prescribed a series of therapy treatments that are medically necessary for you to get the maximum benefit from your rehabilitation program. If you are unable to keep this appointment, kindly give 24 hour notice so that we may continue to accommodate all of our patients.

## PATIENT INFORMATION

Date:

| Social Security Number | Last Name | First Name | MI | Email Address |
|---|---|---|---|---|
| | | | | |

| Address | Zip Code | | State | Home Telephone Number |
|---|---|---|---|---|
| | | | | |

| Date of Birth | Sex (Circle one) Male or Female | If minor name of parent or guardian |
|---|---|---|
| | | |

| Martial Status (Circle One) | Employment Status (Circle One) | Student (Circle One) | Relationship to Insured (Circle One) |
|---|---|---|---|
| Married Divorced Single Widowed Separated | Retired Full Part None | Full Part None | Child Self Spouse Other |

| Employer | Position |
|---|---|
| | |

| Address | Zip Code | City | State | Employer's Phone Number |
|---|---|---|---|---|
| | | | | |

## RESPONSIBLE PARTY ( If Patient is responsible party, skip this section )

| Employed (Circle) Yes No | Last Name | First Name | MI |
|---|---|---|---|
| | | | |

| Address | Zip Code | City | State |
|---|---|---|---|
| | | | |

| Relationship to Insured (Circle One) Child Self Spouse Other | Social Security Number | Date of Birth |
|---|---|---|
| | | |

| Employer | Position | Business Phone Number/CellPhone # |
|---|---|---|
| | | |

## INSURANCE INFORMATION

| Primary Insurance Company | Policy # : | Name of Insured |
|---|---|---|
| | Group #: | Social Security #: |
| Address: | ID # | Date of Birth: |
| | | |

| Secondary Insurance Company | Policy #: | Name of Insured |
|---|---|---|
| | Group #: | Social Security #: |
| Address: | ID # : | Date of Birth: |
| | | |

| Employer: | Relationship to Insured ( Circle One ) Child Self Spouse Other |
|---|---|
| | |

## EMERGENCY INFORMATION

| Person to contact in case of Emergency | Relationship | Phone Number to Contact | |
|---|---|---|---|
| | | | |

| Address | City | State | Zip |
|---|---|---|---|
| | | | |

## INJURY INFORMATION

| Job Related: Yes No | Circle One: Injury Illness | Was this due to an Auto Accident: Yes No |
|---|---|---|
| | | |

| Date of First Symptom or Accident | If Job Related Phone # to Verify or Name of Person to Contact |
|---|---|
| | |

| If Job Related Name of Employer at Time of Accident | How did Injury Occur |
|---|---|
| | |

| Where did Injury Occur | Area of Injury Symptom |
|---|---|
| | |

If Auto Accident, name and phone number of Auto Insurance Carrier

| Claim # | State in which injury occurred |
|---|---|
| | |

I authorize the release of appointment or account information left on the voicemail or message center at:

Home Phone Number Cell Phone Number Work Phone Number

EMORY HEALTHCARE

# MEDICAL HISTORY / SUBJECTIVE INFORMATION

Name: _____ Date: ___/___/_____ Birthdate: ___/___/_____ Age: _____

Height: _____ Weight: _____ Referring MD: _____ Phone #: _____

Diagnosis: _____

**Medical History: (Please check all that apply)**

| | | | | |
|---|---|---|---|---|
| ___ Heart Disease | ___ Diabetes | ___ High Blood Pressure | ___ Pacemaker | ___Sleep Apnea |
| ___ Cancer | ___ Tuberculosis | ___ Visual Impaired | ___ Epilepsy | ___ Fever |
| ___ HIV/AIDS | ___ Arthritis | ___ Hearing Impaired | ___ Fibromyalgia | ___ Malaise |
| ___ Stroke | ___ Asthma | ___ Latex Allergy | ___ Scoliosis | ___ Infection |
| ___ Osteoporosis | ___ Hepatitis | ___ Allergies | ___ Headaches | ___ Weight Loss/Gain |
| ___ Chest Pain | ___ Kidney Problems | ___ Pregnant | ___ Seizures | ___ Thyroid |
| ___ Metal Implants | ___ Dizziness | ___ Fractures | ___ Ear Ringing | ___ Lupus |
| ___ Osteoarthritis | ___ Blood Clots | ___ Depression | ___ Gout | ___ High Cholesterol |

If you answered **yes** to any of the above, please explain: _____

Therapist comments: _____

Have you had surgery for your condition? Y N If yes, please give approximate date: _____
Have you had any injections for your condition? Y N If yes, please give approximate date: _____
Please list any diagnostic tests you have had for this condition: _____
Please list any medications that you are taking: _____
What are your current symptoms? _____
How and when did the injury or problem occur? _____
Have you had any prior treatment for your current problem?_____

**Please rate your pain using a 0 – 10 scale** (0 = no pain, 10 = the worst pain you can imagine)
Worst pain since onset: _____ Best pain since onset: _____ Today's Pain: _____
Where is your pain or problem located?_____ Is your pain? ____ Constant ____ Intermittent
What makes your pain / problem better?_____ Worse? _____
Is there pain present at night? Y N What position helps you to sleep? _____

Therapist comments: _____

**<u>Employment History:</u>**
Are you currently working? Y N If no, how many total days of work have you missed?_____
Are your work duties? Full Restricted How many hours per week do you work?_____
Who is your employer?_____
What type of work do you do?_____
What critical work duties have been most affected by your problem?_____

**What do you hope to accomplish with therapy**? _____
_____

EMORY HEALTHCARE

**PLEASE RATE YOUR ABILITIES USING THE FOLLOWING SCALE:**

**1 = CAN DO WITHOUT DIFFICULTY**

**2 = CAN DO WITH SOME DIFFICULTY**

**3 = CAN DO WITH GREAT DIFFICULTY**

**4 = CAN'T DO AT ALL**

**Comments: Therapist use only**

| | | | | | |
|---|---|---|---|---|---|
| Lying Down | 1 | 2 | 3 | 4 | _____ |
| Sitting | 1 | 2 | 3 | 4 | _____ |
| Standing | 1 | 2 | 3 | 4 | _____ |
| Walking | 1 | 2 | 3 | 4 | _____ |
| Jogging/running | 1 | 2 | 3 | 4 | _____ |
| Going up stairs | 1 | 2 | 3 | 4 | _____ |
| Going down stairs | 1 | 2 | 3 | 4 | _____ |
| Lifting/carrying | 1 | 2 | 3 | 4 | _____ |
| Driving a car | 1 | 2 | 3 | 4 | _____ |
| Overhead reaching | 1 | 2 | 3 | 4 | _____ |
| Housework | 1 | 2 | 3 | 4 | _____ |
| Yardwork | 1 | 2 | 3 | 4 | _____ |
| Dressing | 1 | 2 | 3 | 4 | _____ |
| Sleep | 1 | 2 | 3 | 4 | _____ |
| Other: _____ | 1 | 2 | 3 | 4 | _____ |

| | | | | |
|---|---|---|---|---|
| Are you exercising at home? | Y | N | If yes, what type? | _____ |
| Are you using heat or cold? | Y | N | If yes, what type? | _____ |
| Are you wearing a sling or brace? | Y | N | If yes, what type? | _____ |
| Do you smoke? | Y | N | If yes, how much? | _____ |
| Do you drink alcohol? | Y | N | If yes, how much/often? | _____ |

What type of non-work activities are you involved in? _____

When are you scheduled to see your doctor again? _____

Therapist comments: _ _____

_____

_____

Therapist Signature: _____

**To the best of my knowledge and belief, the information I have given is complete and true. I hereby give my consent to receive therapy services at _____.**

EMORY
HEALTHCARE

# ATTENDANCE POLICY

One of the most important things that you can do to contribute to your progress in therapy is to make the commitment to show up for your scheduled appointments. Your therapist develops an individualized treatment plan based on your physician's recommendations and your diagnosis. It is vital to measure your improvement regularly to report to your physician and to ensure that you can advance through your plan of care. We have a large volume of physicians and patients who desire the high-quality care provided by the therapists at this clinic which makes it even more imperative that patients attend their scheduled sessions.

If you arrive more than 15 minutes after your scheduled time, your therapist may need to reschedule your appointment later that day or to another day.

If you do not call to cancel and/or reschedule your appointment and miss your scheduled appointment, we may be obligated by contract to notify your physician, insurance carrier, case manager and/or employer for workers compensation cases.

If you cancel two or more appointments for unexplained reasons or do not show up for two or more appointments, we will cancel all remaining appointments to allow patients on our waiting list to be seen.

If you are not able to attend your therapy session, please call at least 24 hours in advance to cancel. If you cancel less than 24 hours before your scheduled appointment, we reserve the right to charge a $25 Cancellation Fee. If you do not call to cancel and do not show up for a therapy session you will be charged a $25 Cancellation Fee. Thank you in advance for your cooperation.

I certify by my signature that I have read the above Attendance Policy and will comply.

Signature of Patient or Parent/Responsible Party _____

Printed Name of Patient or Parent/Responsible Party _____

Relationship to Patient _____ Date_____

What is the best way for us to contact you?

Home Phone: _____
Work Phone: _____
Mobile Phone: _____

EMORY HEALTHCARE EMORY UNIVERSITY

## *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 health care 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 Orthopaedics and Spine Hospital, Emory University Hospital Midtown, Emory Johns Creek Hospital, Emory Saint Joseph's Hospital, Emory Clinic, Emory Children's Center, Emory Specialty Associates, Emory Wesley Woods Center and Emory Dialysis Center. Emory Healthcare facilities are clinically integrated and part of an organized health care arrangement with its components and other components of Emory University, such as the School of Medicine. On occasion, we may disclose health information with these components of the University and the University may disclose health information to Emory Healthcare if necessary to carry out treatment, payment or health care 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 through your signing 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 health care personnel who are involved in taking care of you at Emory Healthcare or at another health care 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 that 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 health care 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 health care 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 health care 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 judgment 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.

**Health Information Exchanges (HIE)** – Health information exchanges allow health care providers, including Emory Healthcare, to share and receive information about patients, which assists in the coordination of patient care. Emory Healthcare participates in a health information exchange that may make your health information available to other providers, health plans, and health care clearinghouses for treatment or payment purposes. Your health information may be included in the health information exchange. We may also make your health information available to other health exchange services that request your information for coordination of your treatment and/or payment for services rendered to you. Participation in the health information exchange is voluntary, and you have the right to opt out. Please see the "**Right to Request Restrictions" section to learn about opting out of the HIE**. Additional information on Emory Healthcare's HIE can be found at our website, www.emoryhealthcare.org/ehealthexchange.

**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. If you elect, we may also send appointment reminders via text message or email. 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** – As a nonprofit health system, support from generous patients and families builds Emory Healthcare and the Robert W. Woodruff Health Sciences Center and remains essential to continue life-saving health care, research, and education operations**.** We may use health information to contact you for fundraising opportunities. We are allowed to and may use demographic information to contact you, such as your name, address, phone number, or date of birth. We may also use the dates you received treatment or services, department of service, outcomes information, and treating physician information. You have the right to opt out of fundraising communications. If you do not want Emory Healthcare or the Woodruff Health Sciences Center to contact you for fundraising efforts, you may opt out by calling 404-727-7111, emailing askemory@emory.edu, or by submitting the request in writing to the Development and Alumni Relations Office, Robert W. Woodruff Health Sciences Center, 1440 Clifton Road, Suite 116, Atlanta, Georgia 30322. Your decision whether or not to receive fundraising communications will not affect your ability to receive health care services at Emory Healthcare.

**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 to 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 or 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 Donations –** 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 that 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, counterintelligence, 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 institution 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**

Most uses and disclosures of psychotherapy notes, uses and disclosures for marketing purposes, disclosures that constitute a sale of health information, and other types of uses and disclosures of your health information not described in this Notice require an authorization and 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. 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, your contact information, date of birth and dates of service if known. To the extent that your health information is maintained electronically and you request the information in an electronic format, to the extent possible we will provide you a machine readable copy. 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. Emory Healthcare might not retain medical records from other facilities for inclusion in your medical record or designated record set. These could include radiology films, scans or compact discs that were or might be provided to your Emory Healthcare provider. Please check with your physician or clinic administrator if you have any questions regarding this policy.
**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 records 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 health care operations,
- pursuant to an authorization,
- incident to a permitted use or disclosure, or
- for 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, 2nd Floor, Suite 242, 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 werebefore 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 the Emory Healthcare Privacy Office, 101 West Ponce de Leon Ave, 2nd Floor, Suite 242, 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, 2nd Floor, Suite 242, 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 the Emory Healthcare Privacy Office, 101 West Ponce de Leon Avenue, 2nd Floor, Suite 242, Decatur, Georgia 30030.
**Right to Receive Notification of a Breach of Your Health 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 notify you as required by law. The law may not require notice to you in all cases. In some situations, even if the law does not require notification, we may choose to notify you.**

**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 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, 2nd Floor, Suite 242, Decatur, GA 30030.
You may also file a complaint with the Secretary of the Department of Health and Human Services, http://www.hhs.gov/ocr/privacy/hipaa/complaints. 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, 2nd Floor, Suite 242, Decatur, GA 30030 or call 404-778-2757.