



**Northern Louisiana  
Medical Center**  
**TECH CARE**

**Patient Information:**

Patient (Legal) Name: \_\_\_\_\_ Date: \_\_\_\_\_

Billing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Patient Date of Birth: \_\_\_\_\_ SSN# \_\_\_\_\_ Sex: \_\_\_\_\_

Race: \_\_\_\_\_ Marital Status: \_\_\_\_\_ Occupation: \_\_\_\_\_

Primary Care Physician/Location: \_\_\_\_\_

Preferred Pharmacy/Location: \_\_\_\_\_

**Emergency Contact:**

Emergency Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Relation to Patient: \_\_\_\_\_

**Patients less than 17 years of age only:**

Guarantor Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

**Primary Insurance:**

Name of Insurance Company: \_\_\_\_\_

Name of Insured: \_\_\_\_\_ Insured Policy: \_\_\_\_\_

Relation to Patient: \_\_\_\_\_ Insured Date of Birth: \_\_\_\_\_

**Secondary Insurance:**

Name of Insurance Company: \_\_\_\_\_

Name of Insured: \_\_\_\_\_ Insured Policy: \_\_\_\_\_

Relation to Patient: \_\_\_\_\_ Insured Date of Birth: \_\_\_\_\_



**Northern Louisiana  
Medical Center**  
**TECH CARE**

Permission to Verbally Discuss Protected Health Information

I, (patient name) \_\_\_\_\_, give Northern Louisiana Medical Center Tech Care permission to verbally share my health information with the following individuals listed below that I have identified as being involved in my health care, care coordination, or payment of health care. I understand that this form does not authorize releasing copies of my records. I understand that this permission remains in effect until the time I revoke it in writing.

Name: \_\_\_\_\_  
Relationship to patient: \_\_\_\_\_ Phone: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_

Name: \_\_\_\_\_  
Relationship to patient: \_\_\_\_\_ Phone: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_

Name: \_\_\_\_\_  
Relationship to patient: \_\_\_\_\_ Phone: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_

Patient name (print): \_\_\_\_\_

Patient signature: \_\_\_\_\_

Date: \_\_\_\_\_



**1. GENERAL CONSENT FOR TESTS, TREATMENT, PHOTO, VIDEO, AND SERVICES:**

I consent to treatment / admission to the Facility. I permit the Facility and its employees, physicians, fellows, residents, interns, and others involved in my care to treat me in ways they judge to be beneficial to me. I have a right to ask questions and to receive information about my care and treatment, and the right to withdraw my consent for treatment or tests.

I consent to examinations, blood tests (including blood tests for communicable diseases such as hepatitis and HIV/AIDS when health care personnel have been exposed to my blood and/or body fluids), laboratory and imaging procedures, medications, infusions, nursing care and other services or treatments given by my physician, consulting physicians, fellows, residents, interns, and their associates and assistants, or given by Facility personnel under the instructions, orders or direction of such physician(s), fellow(s), resident(s), or intern(s).

I have been informed of the treatment/procedures considered necessary for me and that the treatments/procedures will be directed by a physician and may be performed by a physician or one or more additional physicians, fellows, residents, interns, and employees of the Facility, who may treat me or participate in my treatment. I understand that no guarantee or assurance has been made regarding (1) which physicians and/or fellows, residents, or interns will treat me or participate in my treatment and/or (2) the results that may be obtained from treatment. I agree and understand that all individuals involved in my care are responsible and liable for their own acts and omissions, and the Facility is not responsible or liable for their acts or omissions. Services may be performed by independent contractors who are not employed by the Facility. I am aware the practice of medicine is not an exact science and understand that no guarantee has been or can be made for the results of treatments, care or examinations in the Facility.

I consent to the photographing, videotaping and/or video monitoring, of appropriate portions of my body, for medical and medical record documentation purposes, as long as such photographs or videotapes are maintained and released in accordance with protected health information regulations.

I consent to virtual health/telemedicine services as part of my treatment. I understand that "virtual health" or telemedicine services include the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications.

I understand that medical, nursing, and other authorized health care providers in training may be observing and participating actively in my care under the supervision of authorized personnel. I give my consent to such observations and/or participation.

**2. ASSIGNMENT OF INSURANCE BENEFITS / PROMISE TO PAY:**

I assign to the Facility or as necessary to any Facility-based physician (for the purposes of this section, collectively the "Facility") all of my rights and benefits under existing policies of insurance providing coverage and payment for any expenses incurred as a result of services and treatment rendered by the Facility or any independent contractor. I authorize direct payment to the Facility or to any independent contractor of any insurance benefits otherwise payable to or on behalf of myself. Further, I hereby authorize my plan administrator, fiduciary, insurer, and/or attorney to release to the Facility any and all documents related to my insurance plan, summary benefit description, insurance policy(ies), and/or settlement information upon written request from the Facility.

*(continued on page 2)*

\_\_\_\_\_ *Initials*

Patient Label

(continued from page 1)

I irrevocably appoint the Facility as my authorized representative to pursue any claims, penalties, and administrative and/or legal remedies on my behalf for collection against any responsible payer, employer-sponsored medical benefit plans, third party liability carrier, or any other responsible third party. I acknowledge that the Facility is not obligated to pursue any such claims.

In addition, I grant the Facility power of attorney to pursue any claims, penalties, and administration and/or legal remedies for collection against any responsible payer, employer sponsored medical benefit plans, third party liability carrier, or any other responsible third party. This power of attorney shall not be affected by subsequent disability or incapacity of me. This is not a power of attorney for health care decisions generally, and the powers granted hereby are expressly limited to those reasonably required to collect any payments or benefits under any policy of life, accident, disability, hospitalization, medical or casualty insurance.

I assign to the Facility all insurance benefits, sick benefits, injury benefits, or proceeds of claims resulting from the liability of a third party unless my account is paid in full when I am discharged or finish my outpatient care.

If I am eligible for Medicare, I request Medicare services and benefits. I agree this assignment will not be withdrawn until my account is paid in full. I understand I am responsible to pay any account balance for applicable coinsurance and deductible amounts and for those amounts not otherwise covered by my insurance company in accordance with the regular rates and terms of the Facility.

I understand I am responsible to pay any account balance not covered by my insurance company in accordance with the standard charges that the Facility bills for such services. If I do not make payments when due and the account is turned over for collection, I agree to pay all collection agency fees, court costs and attorneys' fees. I also agree that any patient or guarantor overpayments may be applied directly to past due account. I consent for the Facility to work on my behalf with my insurance company/companies to get authorization or appeal any denial for reimbursement, coverage, or payment for services or care provided to me.

**3. NURSING CARE:**

The Facility provides only routine nursing care. Private duty nursing is not provided but may be arranged directly between an agency and me at my expense. I release Facility from any and all liability arising from the fact that I am not provided private nursing care.

**4. EMTALA:**

During the time period that the federal government has invoked 1135 waivers in order to deal with the emergency COVID-19 crisis, if I have a medical emergency or if I am a pregnant woman in labor, I understand that the Hospital will do its best to provide care in the setting most appropriate and within the capabilities of this Hospital's staff and facilities, including an appropriate medical screening exam, stabilizing treatment, and, if medically necessary, an appropriate transfer to another hospital, even if I cannot pay or do not have medical insurance or am not eligible to receive Medicare or Medicaid.

**5. PERSONAL VALUABLES:**

I understand that the Facility is not liable for the loss or damage to any articles of personal valuables unless I have given them to the Facility to be put in the safe and been given a receipt by Facility for their safe return. At no time will the Facility be responsible for more than \$500 for my deposited items.

(continued on page 3)

\_\_\_\_\_ Initials

(continued from page 2)

**6. WEAPON / EXPLOSIVES / DRUGS:**

I understand and agree that if the Facility at any time believes there may be a weapon, explosive device, biohazard material, any type of illegal substance or drug, or any alcoholic beverage in my room or with my belongings, the Facility may search my room and belongings, confiscate any of the above items that are found, and dispose of them as it determines appropriate, including giving them to law enforcement.

**7. CONSENT TO RELEASE HEALTH INFORMATION:**

I understand this Facility uses an electronic medical record. I understand that the electronic medical record contains information about my health from my past, current and future health care providers. I agree that this health information may be released through the Facility's electronic medical record or by other means (for example, fax, telephone, email, or hand delivery): (1) to the Facility; (2) to my past, current and future health care providers and other health care organizations that provide care to me; (3) to the health insurance company named in my medical record; and (4) to any other person named in my medical record who pays for my treatment. These people may use my health information: (1) to treat me; (2) to get paid for my treatment (for example, billing insurance companies), and (3) to do health care operations activities (for example, managing my care, providing quality care, patient safety activities, and other activities necessary to run the Facility). I understand that these people will have access to all my health information in the medical record, including behavioral health and substance use disorder information (for example, drug and alcohol treatment), my medical history, diagnosis, hospital records, clinic and doctor visit information, medications, allergies, lab test results, radiology reports, sexual and reproductive health information, communicable disease-related information (for example, sexually transmitted diseases), and HIV/AIDS-related information. I understand that I may take back this consent at any time, except if my health information has already been released to someone. I also understand that I may request a list of the health care organizations that have received my substance use disorder information. This consent will expire one year after my death.

**8. NOTICE OF PRIVACY PRACTICES:**

I have received a copy of the Facility's Notice of Privacy Practices and consent to the use and disclosure of my protected health information as described in the Notice of Privacy Practices. This will include all of my protected health information generated during hospitalization and outpatient treatment at the Facility, including but not limited to treatment for mental health, drug and alcohol abuse, communicable diseases such as HIV/AIDS, developmental disabilities, genetic testing, and other types of treatment received.

Please initial one option:

\_\_\_\_\_ I give the Facility permission to disclose my name, room number, and general condition to anyone who inquires during my stay at the Facility.

\_\_\_\_\_ I do not give permission to the Facility to disclose information about my presence at the Facility during my stay. I realize that by choosing this options, I will not be able to receive flowers, cards, phone calls, family/visitors or clergy visits.

(continued on page 4)

\_\_\_\_\_ Initials

(continued from page 3)

**9. RESEARCH STUDIES: Please initial:**

Yes  No Are you currently a participant in any research study or project: *If yes, please briefly describe what is being studied (drug, medical device or other)* \_\_\_\_\_

Who can the Facility contact with questions about the study? \_\_\_\_\_

**10. COMMUNICATIONS:**

I consent to this Facility, its successors or assignees contacting me via the methods I provide to the Facility. I understand the communications may occur in any manner, including phone calls to my cell phone or landline, voicemails on my cell phone or landline, use of automated telephone dialing systems, use of artificial or prerecorded voice messages, text messages to my cell phone, or email messages. I understand the communications may be about any matter, including, but not limited to, my medical treatment, prescriptions, insurance eligibility, insurance coverage, scheduling, billing or collection matters. I understand that these communications are not encrypted or secure, and I assume the risks of transmitting health information via unsecure means. If I incur any cost from being contacted at the telephone number(s) or email address(es) provided to the Facility, including but not limited to data, roaming, text messages, additional minutes or other fees, I understand that the Facility is not responsible for paying these charges. This consent also applies to any updated or additional contact information that I may provide. I understand that I will be able to change my preference at any time by contacting the Facility.

**11. EXTERNAL PHARMACY:**

I consent to the exchange of prescription information between the facility and my pharmacy(ies).

**12. VIDEOTAPING/RECORDING:**

I agree not to photograph, video record, audio record, or otherwise capture imaging or sound on any device. I also understand it is my responsibility to assure my visitors comply with this requirement.

**13. ED NAVIGATOR PROGRAM:**

If this facility offers an ED Navigator Program which provides information and assistance to patients who request help obtaining a referral to a Primary Care Physician, the ED Navigator Program disclosures are attached hereto as Exhibit: "ED Navigator Program Disclosures" and incorporated herein by reference. By signing this consent, Patient affirms that the ED Navigator Program disclosures have been effectively communicated to the Patient and the Patient has had the opportunity to have any questions regarding the ED Navigator Program answered to his/her satisfaction."

**14. OUT-OF-NETWORK SERVICES:**

I understand that the Facility may not participate in my medical health insurance network or my health insurance carrier may not have any established health insurance networks with hospitals or other provider groups. I understand that even where the Facility participates in my medical health insurance network, some physicians or other healthcare providers who may not be employed by this Facility and who may not participate in my insurance network, such as

(continued on page 5)

\_\_\_\_\_ Initials

(continued from page 4)

anesthesiologists, radiologists, emergency room physicians, and pathologists, may be called upon to render healthcare items or services during the course of treatment at the Facility that may be billed separately. The list of such specialists is available on the Facility's website, and that listing is incorporated herein by reference. I understand and acknowledge that, when the Facility or provider or particular specialist does not participate in my medical health insurance network, the Facility or provider or specialist, as applicable, is not bound by the payment provisions that apply to health care items or services rendered by a network provider under my health insurance plan.

I acknowledge that I have the right to verify or confirm and, prior to receiving services, have verified or confirmed or had the opportunity to with my insurance carrier to find out if the Facility or medical care providers involved in my treatment at the Facility are in-network and to obtain a list of network providers that may render the health care items or services I request. I understand if I do not verify places me at risk of higher out-of-network charges due to a possible benefit reduction.

Finally, I acknowledge and understand that, if I am to receive medical care by a healthcare provider not in my insurance network, I will be billed at 100% of the standard charges that the Facility bills for such services, which I can view on the Facility's website or upon request, to the extent permitted under state law. I further acknowledge that I am responsible to pay any account balance not covered by my insurance company, in accordance with the standard charges that the Facility bills for such services to the extent permitted under state law. Under these circumstances, if I do not make payments when due and the account is turned over for collection, I agree to pay all collection agency fees, court costs and attorneys' fees. I also agree that any patient or guarantor overpayments may be applied directly to any past due account. I consent for the Facility to work on my behalf with my insurance company/companies to get authorization or appeal any denial for reimbursement, coverage, or payment for services or care provided to me pursuant to the assignment of benefits set forth herein.

The undersigned certifies that s/he has read (or have had read to me) the foregoing, understands it, accepts its terms, and has received a copy of. I hereby agree to all terms and conditions set forth above.

Patient's Signature or Legal Representative		Date/Time
Relationship to Patient	Interpreter, if Utilized	Date/Time
Witness Signature		Date/Time

Inpatient/Outpatient Conditions of Admission and  
Consent to Medical Treatment  
ADM-1703GHMS  
(Rev. 11/15, 01/16, 06/16, 01/17, 11/17, 02/18, 05/19, 03/20, 11/20)  
ORIGINAL - Medical Record      COPY - Recipient

Patient Label



**Northern Louisiana  
Medical Center**  

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**TECH CARE**

Acknowledgement of Receipt of Privacy Practices

I acknowledge that I have received a copy of the *Privacy Practices*.

Printed name of Patient or Representative: \_\_\_\_\_

Signature of Patient or Representative: \_\_\_\_\_

Date: \_\_\_\_\_

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For office use only:

The patient was provided a copy of the *Privacy Practices* and a good faith effort was made to obtain the patient's signature of acknowledgement. However, an acknowledgement signature could not be obtained because:

\_\_\_\_\_  
\_\_\_\_\_

Signature of Office Representative: \_\_\_\_\_

Date: \_\_\_\_\_





**Northern Louisiana  
Medical Center**  
**TECH CARE**

Acknowledgement of Receipt of Patient Rights and Responsibilities

I acknowledge that I have received a copy of the *Patient Rights and Responsibilities*.

Printed name of Patient or Representative: \_\_\_\_\_

Signature of Patient or Representative: \_\_\_\_\_

Date: \_\_\_\_\_

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For office use only:

The patient was provided a copy of the *Patient Rights and Responsibilities* and a good faith effort was made to obtain the patient's signature of acknowledgement. However, an acknowledgement signature could not be obtained because:

\_\_\_\_\_  
\_\_\_\_\_

Signature of Office Representative: \_\_\_\_\_

Date: \_\_\_\_\_

## 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.*

### WHO WILL FOLLOW THIS NOTICE

This notice describes our hospital's practices and that of:

- Any health care professional, physicians, or therapists authorized to enter information into your hospital chart.
- All departments and units of the hospital.
- Any member of a volunteer group we allow to help you while you are in the hospital.
- All employees, staff, and other hospital personnel.
- All these entities, sites and locations follow the terms of this notice. In addition, these entities, sites and locations may share medical information with each other for treatment, payment of hospital operations and purposes described in this notice.

### OUR PLEDGE REGARDING MEDICAL INFORMATION

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive at the hospital. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by the hospital, whether made by hospital personnel or your personal doctor. Your personal doctor may have different policies or notices regarding the doctor's use and disclosure of your medical information created in the doctor's office or clinic.

This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

We are required by law to:

- Make sure that medical information that identifies you is kept private.
- Give you this notice of our legal duties and privacy practices with respect to medical information about you; and
- Follow the terms of this notice that are currently in effect.

### HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

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

**For Payment** We may use and disclose medical information about you so that the treatment and services you receive at the hospital may be billed to and payment may be collected from you, an insurance company, or a third party. For example, we may need to give your health plan information about surgery you received at the hospital so your health plan will pay us or reimburse you for the surgery. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

**Appointment Reminders** We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or medical care at the hospital.

**Treatment Alternatives** We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

**For Health Care Operations** We may use and disclose medical information about you for the hospital operations. These uses and disclosures are necessary to run the hospital and make sure that all of our patients receive quality care. For example, we may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine medical information about many hospital patients to decide what additional services the hospital should offer, what services are not needed, and whether certain new treatments are effective. We may also disclose information to doctors, nurses, technicians, medical students, and other hospital personnel for review and learning purposes. We may also combine the medical information we have with medical information from other hospitals to compare how we are doing and see where we can make improvements for the care and services we offer. We may remove information that identifies you from this set of medical information so others may use it to study health care and health care delivery without learning who the specific patients are.

**Health-Related Benefits and Services** We may use and disclose medical information to tell you about health-related benefits or services that may be of interest to you.

**Fundraising Activities** We may use medical information about you to contact you in an effort to raise money for the hospital and its operations. We may disclose medical information to a foundation related to the hospital so that the foundation may contact you in raising money for the hospital. We only would release contact information, such as your name, address, and phone number and the dates you received treatment or services at the hospital. If you do not want the hospital to contact you for fundraising efforts, you must notify the hospital in writing.

**Hospital Directory** We may include certain limited information about you in the hospital directory while you are a patient at the hospital. This information may include your name, location in the hospital, your general condition (e.g., fair, stable, etc.) and your religious affiliation. The directory information, except for your religious affiliation, may also be released to people who ask for you by name. Your religious affiliation may be given to a member of the clergy, such as a priest or rabbi, even if they don't ask for you by name. This is so your family, friends and clergy can visit you in the hospital and generally know how you are doing.

**Individuals Involved in Your Care or Payment for Your Care** We may release medical information about you to a friend or family member who is involved in your medical care. If you are unavailable, incapacitated, or facing an emergency medical situation and we determine that a limited disclosure may be in your best interest, we may share personal health information to individuals without your approval. We may also give information to someone who helps pay for your care. We may also tell your family or friends your condition and that you are in the hospital. In addition, we may disclose medical 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.

**Research** We may release your personal health information for certain research purposes when approved by a review board with established rules to ensure privacy.

**As Required by Law** We will discuss medical information about you when required to do so by federal, state or local law.

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

## **SPECIAL SITUATIONS**

**Organ and Tissue Donation** If you are an organ donor, we may release medical information 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** If you are a member of the armed forces, we may release medical information about you as required by military command authorities.

We may also release medical information about foreign military personnel to the appropriate foreign military authority.

**Employers** We may release to your employer medical information about you when we have provided health care to you at the request of your employer.

**Workers' Compensation** We may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illnesses.

**Public Health Risks** We may disclose medical information about you for public health activities. These activities generally include the following:

- To prevent or control disease, injury or disability;
- To report births and deaths;
- To report child abuse or neglect;
- To report reactions to medications or problems with products;
- To notify people of recalls of products they may be using;
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- To 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** We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

**Data Breach Notification Purposes** We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information.

**Lawsuits and Disputes** If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical 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 information requested.

**Law Enforcement** We may release medical information if asked to do so by a law enforcement official:

- In response to a court order, subpoena, warrant, summons or similar process;
- To identify or locate a suspect, fugitive, material witness, or missing person.
- About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
- About a death we believe may be the result of criminal conduct;
- About criminal conduct at the hospital; and
- In emergency circumstances to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

**Coroners, Medical Examiners and Funeral Directors** We may release medical information 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 medical information about patients of the hospital to funeral directors as necessary to carry out their duties.

**National Security and Intelligence Activities** We may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

**Inmates** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release information about you to the correctional institution or 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.

## **YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU**

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

**Right to Inspect and Copy** You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually this includes medical and billing records, but does not include psychotherapy notes.

To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to Privacy Officer. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by the hospital will review your request and the denial. The person conducting the review will not be the person who denied the request. We will comply with the outcome of the review.

**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 the right to request an amendment for as long as the information is kept by or for the hospital.

To request an amendment, your request must be made in writing and submitted to Privacy Officer. In addition, you must provide a reason that supports your request.

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 information that:

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

**Right to an Electronic Copy of Electronic Medical Records** If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your Protected Health Information in the form or format you request, if it is readily producible in such form or format. If the Protected Health Information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

**Right to Get Notice of a Breach** You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

**Right to an Accounting of Disclosures** You have the right to request an "accounting of disclosures". This is a list of the disclosures we made of medical information.

To request this list or accounting of disclosures, you must submit your request in writing to Privacy Officer. Your request must state a time period which may not be longer than six years and may not include dates before October 16, 2016. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a twelve (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 medical information we use or disclose about you for treatment and payment of health care operations. You also have the right to request a limit on the medical 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.

**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 on the consent form you sign when you become a patient. 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.

**Out-of-Pocket-Payments** If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

**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 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.

**Right to a Paper Copy of This Notice** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

This provider complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Este proveedor cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos por motivos de raza, color, nacionalidad, edad, discapacidad o sexo.

ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call 1-318-254-2100 (TTY: 1-800-846-5277).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-318-254-2100 (TTY: 1-800-846-5277).

Ce fournisseur respecte les lois fédérales en vigueur relatives aux droits civils et ne pratique aucune discrimination base sur la race, la couleur de peau, l'origine nationale, l'âge, un handicap ou le sexe.

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement.  
Appelez le 1-318-254-2100 (ATS: 1-800-846-5277).

## **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 medical information we already have about you as well as any information we receive in the future. In addition, each time you register at or are admitted to the hospital for treatment or health care services as an inpatient or outpatient, we will offer you a copy of the current notice in effect.

## COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the hospital or with the Secretary of the Department of Health and Human Services. To file a complaint with the hospital, contact us at 1-318-254-2100. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

## OTHER USES OF MEDICAL INFORMATION

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information 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, and that we are required to retain our records of the care that we provided to you.



## Summary of Patient's Rights and Responsibilities

As a patient or patient representative, you have certain rights and responsibilities, which are protected by federal and state law. As a part of your healthcare team, we are committed to honoring your rights. Below, we want to summarize these rights and bring to your attention a few patient responsibilities.

### Your Rights

- You have the right to receive considerate, respectful and compassionate care in a safe setting regardless of your age, gender, race, national origin, religion, sexual orientation, gender identity or disabilities.
- You have the right to receive care in a safe environment free from all forms of abuse, neglect, or mistreatment.
- You have the right to be called by your proper name and to be in an environment that maintains dignity and adds to a positive self-image.
- You have the right to be told the names of your doctors, nurses, and all health care team members directing and/or providing your care.
- You have the right to have a family member or person of your choice and your own doctor notified promptly of your clinic visit.
- You have the right to have someone remain with you for emotional support during your clinic visit, unless your visitor's presence compromises your or others' rights, safety or health.
- You have the right to be told, by your doctor, about your diagnosis and possible prognosis, the benefits and risks of treatment, and the expected outcome of treatment, including unexpected outcomes. You have the right to give written informed consent before any non-emergency procedure begins.
- You have the right to have your pain assessed and to be involved in decisions about treating your pain.
- You have the right to be free from restraints and seclusion, in any form that is not medically required, and to have restrictions on your freedom kept to the minimum needed to protect other people.
- You have the right to personal privacy and confidentiality in care discussions, consultations, exams, and treatments. You may ask for an escort during any type of exam. You have the right to access protective and advocacy services in cases of abuse or neglect.
- You and your representative (within limits of State statute), have the right to participate in decisions about your care, treatment, and services provided, including the right to refuse treatment to the extent permitted by law. If you leave the clinic against the advice of your doctor, the clinic and doctors will not be responsible for any medical consequences that may occur.
- You have the right to agree or refuse to take part in medical research studies. You may withdraw from a study at any time without affecting your access to standard care.
- You have the right to sign language and foreign language interpreters, as needed, at no cost to you. Information given to you will be appropriate to your age, understanding, and language. If you have vision, speech, hearing, and/or other impairments, you can receive communication that works for you.
- You have the right to make an advance directive and appoint someone to make health care decisions for you if you are unable. If you do not have an advance directive, we can provide you with information and help you complete one.
- You have the right to be involved in your discharge plan. You can expect communication, in a timely manner, about your discharge or transfer to another facility, or another level of care. Before discharge, you can expect to receive information about follow-up care that you may need.

- You have the right to receive detailed information about your clinic and physician charges. You have the right to know what your care will cost and what your payment options are, before services are provided. You have the right to examine and receive explanation of your bill, regardless of your source of payment.
- You can expect all communication and records about your care to be confidential, unless law permits disclosure. You have the right to review and request amendments to your medical records. You have the right to request a list of people to whom your personal health information was disclosed.
- You have the right to give or refuse consent for recordings, photographs, films, or other images used for internal or external purposes other than identification, diagnosis, or treatment. You have the right to withdraw consent up until a reasonable time before the item is used.
- If you or your representative needs to discuss an ethical issue related to your care, a member of our Administrative team is available at all times. To reach a member, dial 318-245-9739.
- You have the right to request or refuse spiritual services.
- You have the right to voice your concerns about your care without compromise in your current or future access to care. If you have a problem or complaint, you may talk with your doctor, nurse, or a department director. You may also contact the Patient Advocate at 318-254-2720.
- If your concern is not resolved to your liking, you may contact: Louisiana Department of Health (LDH), by mail to Health Standards Section P.O. Box 3767 Baton Rouge, LA 70821, email: hhs.mali@la.gov, by phone to 225.342.0138 or 866.280.7737, or by fax to 225.342.5073.
- To share concerns of discrimination, you can contact the Office of Civil Rights at the U.S. Department of Health and Human Services, 1301 Young Street, Suite 1169, Dallas, TX 75020.

#### Your responsibilities

- Provide complete and accurate information, including your full name, address, and home telephone number, date of birth, Social Security number, insurance carrier and employer when it is required
- Provide the clinic with a copy of your advance directive if you have one
- Provide complete and accurate information about your health and medical history, including present condition, past illnesses, hospital stays, medicines, vitamins, herbal products, and any other matters that pertain to your health, including perceived safety risks
- Ask questions when you do not understand information or instructions. If you believe you cannot follow through with your treatment plan, you are responsible for telling your doctor. You are responsible for outcomes if you do not follow the care, treatment, and service plan.
- Actively participate in your pain management plan and keep your doctors and nurses informed of the progress of your treatment.
- Please leave valuables at home and bring only necessary items for your clinic appointment.
- Treat all clinic staff, other patients, and visitors with courtesy and respect; abide by all clinic rules and safety regulations; and be mindful of noise levels, privacy, and limit visitors.
- Provide complete and accurate information about your health insurance coverage and to pay your bills in a timely manner
- Keep appointments, be on time, and call your health care provider if you cannot keep your appointments.
- You have the responsibility to voice your concerns about the care you receive. If you have a problem or complaint, you should talk with your nurse, doctor, clinic manager, and/or hospital Administration. You may also contact the Patient Advocate at 318-254-2720.