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: _____

Preferred Pharmacy/City: _____

Reason for visit: _____

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: _____ Member ID: _____

Name of Insured: _____

Relation to Patient: _____ Insured Date of Birth: _____

Secondary Insurance:

Name of Insurance Company: _____ Member ID: _____

Name of Insured: _____

Relation to Patient: _____ Insured Date of Birth: _____

Northern Louisiana Medical Center
TECH CARE

PATIENT INFORMATION

NAME:_____ DATE OF BIRTH:_____

PHARMACY:_____ Pharmacy Phone#: _____

MEDICATIONS

List all current medications including prescription, over the counter, vitamins, herbals, and 'as needed' medications.

☐ Check here if patient is not taking any medications at this time.

Medication Name	Dose	How Often

ALLERGIES

List all allergic reactions to medications and/or medical supplies (ex: latex, tapes, adhesives, Band-Aids, iodine)

☐ Check here if patient has no known drug allergies.

Allergic To:	Reaction:

SOCIAL HISTORY

Do you or have you ever smoked tobacco: [ ] Yes [ ] No
Do you or have you ever used any other forms of tobacco or nicotine? [ ] Yes [ ] No
What is your level of alcohol consumption? [ ] None [ ] Occasional [ ] Moderate [ ] Heavy
Do you use any illicit or recreational drugs? [ ] Yes [ ] No

Northern Louisiana Medical Center
TECH CARE

NAME_____ DATE OF BIRTH:_____

SURGICAL HISTORY

List all surgeries or hospitalizations you have had and approximate month/year.

SURGERY/HOSPITALIZATION	MONTH/YEAR

Family/Medical History

Please place a check mark under all that apply.

	SELF	FATHER	MOTHER	CHILDREN	PATERNAL GRANDFATHER	PATERNAL GRANDMOTHER	MATERNAL GRANDFATHER	MATERNAL GRANDMOTHER
Diabetes								
High Blood Pressure								
Heart Disease								
Kidney Disease								
Lung Disease								
Anxiety								
Depression								
Allergies								
Thyroid Problems								
Cancer								
Other								
Other								
Other								

☐ Patient is adopted

☐ Family History is unknown

☐ First-degree relatives have no current problems or disabilities

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: _____

921 Tech Drive, Ruston LA 71270
Phone: (318) 257-4866 Fax: (318) 257-3927/(833) 449-3373

1. GENERAL CONSENT FOR MEDICAL PROCEDURES AND TREATMENT:

Permission is hereby granted to the CLHG Ruston, LLC hospital (Northern Louisiana Medical Center) and/or medical clinics (Allegiance Medical Clinic of Ruston, Allegiance Medical Clinic Northside Family Practice, Allegiance Medical Clinic and Tech Care) for such Medical procedures, and treatment purposes, as may be deemed necessary by my physician and/or his or her designee. I further consent to treatment by authorized employees, physicians, fellows, residents, interns or agents who are assigned to my care. 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 or clinic, who may treat me or participate in my treatment. I understand that no guarantee or assurance has been made regarding which physicians and/or fellows, residents, or interns will treat me or participate in my treatment and/or procedure. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the results of treatments, examinations, emergency services or hospital care. 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 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 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. CONSENT FOR BLOOD BORNE INFECTIOUS DISEASE TESTING:

I hereby give my consent to have testing for blood-borne infectious disease, including but not limited to Hepatitis, Acquired Immune Deficiency Disease Syndrome (AIDS), and Human Immunodeficiency Virus (HIV) if a physician orders such test(s) or if ordered by protocol when health care personnel have been exposed to my blood and/or body fluids. The potential side effects of this testing are those encountered during the routine procedure of obtaining blood specimens. The minor complications may include discomfort from the needle stick and slight burning, bleeding or soreness at the site where blood was obtained. The results of this test will become a part of my confidential medical record. I understand that refusal to consent will not result in denial of admission to this hospital.

3. CONSENT FOR EMERGENCY TREATMENT:

If I am suffering from an emergency medical condition, I know this condition entitles me to an appropriate medical screening exam and treatment necessary to stabilize my condition.

I thereby authorize the Hospital to provide an appropriate medical screening evaluation and treatment, to be performed by or under the supervision of a physician or his/her aide. It has been explained to me that the diagnostic and treatment procedures, which my emergency medical condition legally entitles me, are limited and will include a medical screening examination. It may be necessary for me to select another physician and obtain from him/her a complete diagnosis of my condition and such treatment as he/she may prescribe.

4. 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 the Facility from any and all liability arising from the fact that I am not provided private nursing care.

5. ACKNOWLEDGEMENT OF ADVANCE DIRECTIVE / LIVING WILL AND PATIENT EDUCATION

I have been given the patient education handout and I have been offered Advanced Directives and Living Will information and have been informed that it will be given to me at any time at my request during my hospital or clinic visit.

Do you have a living will? □ Yes □ No

Durable Power of Attorney? □ Yes □ No

6. EMTALA

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.

7. CONSENT TO DISCLOSE PATIENT INFORMATION AND OPT OUT OF THE FACILITY DIRECTORY:

The Hospital will not divulge any identifying information about patients without their consent. With this in mind, we need your permission to release information about your presence at the Hospital during your stay. By choosing to opt out of the Facility directory, your location in the hospital will not be released. In addition, you will not receive flowers, cards, phone calls or clergy visits. Please indicate information that may NOT be included in the hospital's directory (please check all that apply).

□ Name □ Location within Hospital □ Religious Affiliation

(continued on page 3)

_____ *Initials*

(continued from page 2)

8. NOTICE OF PRIVACY PRACTICES:

I acknowledge that I have received a copy of the Notice of Privacy Practices for the CLHG-

Ruston, LLC facilities 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 clinic visits, hospitalization and any outpatient treatments at a CLHG-Ruston, LLC facility. I understand that if I have questions or complaints, I may contact the facility HIPAA Privacy Officer.

☐ Yes ☐ No Date Issued: _____

9. PATIENT RIGHTS AND RESPONSIBILITIES ACKNOWLEDGEMENT:

I acknowledge that I have received a copy of the Patient Rights and Responsibilities and have had an opportunity to ask questions.

10. RELEASE OF INFORMATION

I acknowledge that data from my patient records will be accessible to all health care providers participating in my care or treatment, including but not limited to physicians, nurses, technicians at the hospital, clinics, home care and extended care agencies, ambulance companies, and such other health care agencies involved in my care. I further acknowledge that my medical records will be utilized for utilization review, performance improvement, peer review and other similar processes and studies. I also acknowledge that my medical records will also be available to government agencies as required by law. Information contained in my medical records may be extracted and compiled for research purposes and aggregated results (without individually identifying me) may be released to the public.

I acknowledge that patient medical records may be stored electronically and made available through computer networks through hospital and clinic personnel, as well as physicians involved in my care and their offices. I also acknowledge that should I be treated at another facility or clinic in the area affiliated with CLHG-Ruston, LLC, my medical records may be made electronically available to the other facility or clinic, as well as physicians involved in my care and their offices. This will assist my physician and other caregivers in reviewing past treatment as it may affect my condition and treatment at that time. Facilities or clinics which are not affiliated with CLHG-Ruston, LLC and affiliated facilities, which do not have computerized medical records will not be able to provide this service.

I authorize CLHG-Ruston, LLC hospital and clinics and any physician involved in my care to release medical information and supporting documentation of same as compiled in my medical records during this hospital admission or outpatient visit to any organization that is or may be liable or responsible for payment of charges associated with my care and for all other purposes of benefit payment. If my injury is work related, I authorize CLHG-Ruston, LLC hospital or clinics

(*continued from page 3)*

to release any information from my medical records to my employer and/or its designee. This

authorization specifically includes the release of medical information concerning drug-related conditions, alcoholism, psychological conditions, and/or infectious diseases including but not limited to blood borne.

I authorize the release of my social security number in accordance with federal law and regulations to the manufacturer of any medical device I may receive.

11. ASSIGNMENT OF INSURANCE BENEFITS / PROMISE TO PAY:

This assignment of benefits allows the CLHG-Ruston, LLC hospital and clinics and/or for hospital or clinic based providers to be paid directly by my health insurance carrier or other health benefit plan for the services hospital and clinic provided to me, my minor child, or other person entitled to health care benefits for the service provided. In return for the services rendered, I hereby irrevocably assign and transfer to the CLHG-Ruston, LLC facilities and/or providers all right, title and interest in all benefits payable for the health care rendered, which are provided in any and all insurance policies and health benefit plans from which my dependents or I are entitled to recover. This assignment and transfer shall be for the purpose of granting the CHLG-Ruston, LLC facilities and/or their providers an independent right of recovery against my insurer or health benefit plan, but shall not be construed as an obligation of CLHG-Ruston, LLC facilities and/or providers to pursue such right of recovery. In no event will the CLHG-Ruston, LLC facilities and/or providers retain benefits in excess of the amount owed to the CLHG-Ruston, LLC facilities or providers for the care and treatment rendered.

I have read and been given the opportunity to ask questions about this agreement of benefits, and I have signed this document freely and without inducement, other than the rendition of services by CLHG-Ruston, LLC facilities and providers.

12. OUT OF NETWORK SERVICES

I understand that CLHG-Ruston, LLC facilities 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 CLHG-Ruston, LLC and who may not participate in my insurance network, such as anesthesiologists, radiologists, and pathologists, may be called upon to render healthcare items or services during the course of my treatment 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 CLHG-Ruston, LLC facilities 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 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 CLHG-Ruston, LLC 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.

13. FINANCIAL AGREEMENT

In consideration of the services to be rendered to the patient, the undersigned (as parent, guardian, spouse, guarantor, agent or as the patient) individually promises to pay the patient's account at the rates stated on the CLHG-Ruston, LLC price list (known as the "charge Master") effective on the date the charge is processed for the services provided, which rates are hereby expressly incorporated by reference as the price term of this agreement to pay the patient's account.

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 CLHG-Ruston-LLC facilities and its providers. I understand I am responsible to pay any account balance not covered by my insurance company in accordance with the standard charges that CLHG-Ruston, LLC 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 CLHG-Ruston, LLC facilities and providers 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.

(continued on page 6)

_____ *Initials*

(continued from page 5)

14. MEDICARE PATIENT CERTIFICATION

I certify that the information given by me in applying for payment under Title XVII and Title XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare Claim. I permit a copy of the authorization to be used in place of the original and request payment of authorization of benefits to be made on my behalf.

15. 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.

16. EXTERNAL PHARMACY

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

17. 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.

18. PERSONAL VALUABLES

I understand that the Hospital maintains a safe for the safekeeping of money and valuables, and the Hospital shall not be liable for the loss or damage to any money, jewelry, documents or other articles of unusual value and small size unless placed herein. The Hospital shall not be liable for loss or damage to any personal property the patient chooses to keep in their room including dentures, glasses, hearing aids, prostheses, cell phones, lap tops, i-pads or any other electronic devices, etc.

(continued on page 7)

_____ *Initials*

(continued from page 6)

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.

19. TOBACCO/E-CIGARETTES AND VAPING USE POLICY

All CLHG-Ruston, LLC facilities and associated grounds are tobacco free. I understand that I

may not use tobacco products, e-cigarettes or vape while at the hospital or any of the CLHG-Ruston, LLC clinics.

20. WEAPONS/EXPLOSIVES/DRUGS

I understand and agree that if the Hospital 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 Hospital may search my room and belongings, confiscate any of the above items that are found, and dispose of them as it determines appropriate, including delivery of any item to law enforcement authorities.

CONSENT: I hereby authorize and direct the designated authorized physician/group, together with associates and assistants of his choice, to administer or perform the medical treatment including any additional procedures or services as they may deem necessary or reasonable, including but not limited to radiological services, or laboratory services.

I have read and understand all information set forth in both the General Consent to Treat and the Healthy Lifestyles educational document. This authorization for and consent to medical treatment is and shall remain valid until revoked.

I acknowledge that I have had the opportunity to ask any questions and acknowledge that my questions have been answered to my satisfaction.

_____ _____

Patient or Person Authorized to consent Date/Time

_____

Relationship

If consent is signed by someone other than the patient, state the reason:

_____

_____ _____

Witness Date/Time

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: _____

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: _____

Northern Louisiana Medical Center

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: _____

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

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 bringing 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.mail@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.

Northern Louisiana Medical Center

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 polices 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. Cal 1-318-254-2100 (TTY: 1-800-846-5277).

ATENCION: 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 federales en viguer relatives aux froits civiques et ne pratique aucune discrimination base sur la race, lacouleur de peau, l'origine nationale, l'age, un hándicap ou le sexe.

ATTENTION: Si vios parlez francais, des services d'aide linguistique vous sont proposes gratuitement.
Appelex 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.