St. Francis
Rehabilitation Center

PATIENT INFORMATION SHEET

Today's Date____________ Referring Doctor________________ Primary Care Provider____________________

What part of the body are we treating? ____

Personal Information

Name(Full name only, no nicknames)_____________________________________**DOB**________________

Address____**ZipCode**____________________

Home Phone( )________________________ **Work( )**______________**Cell( )**____________________

****We can now text and email reminders. Who is your cell phone provider:** _____________________________

Sex: M___ F___ SSN_____________________ **Marital Status** ______________**Race**____________________

Religion_______________ Nationality____________________ Email Address:___________________________

Employer _______________________________Occupation____

Employer's Address ______________________________ City________________ State_______ Zip________

Emergency Contact ____

Relationship___________________________ Home Phone( )______________ Cell ( )__________________

Address____ City________________ State_______ Zip________

Are you Disabled? Y__ N__ If yes, what is your disability? ____

Are you Retired? Y___N__ If Yes, what is your retirement date? ______________________________________

Have you verified your benefits? Y__ N__ . If your insurance changes at anytime please inform the front desk

Have you received other outpatient therapy services this year? Y__ N__ If yes, how Many Visits were used?_________

Insurance Information

It is necessary that we receive a copy of all cards in order to verify file your insurance properly
If the patient is not the Policy Holder or a Minor please fill in the policy holder's information

If this is an approved claim through Workman's Compensation please fill the W/C part only.

Primary Insurance____________________________ Policy Number_________________________________

Name of Policy Holder____

Policy Holder's DOB_________ Policy Holder's SSN______________ Policy Holder's Phone( )____________

Secondary Insurance__________________________ Policy Number_______________________________

Name of Policy Holder____

Policy Holder's DOB_________ Policy Holder's SSN______________ Policy Holder's Phone( )____________

Workman's Compensation Information

Date of Injury________________ Adjustor/Contact Name__________________ Phone( )__________________

Claim Number_______________________ Employer when injured(if different than above)_________________

******Please be advised it is your responsibility to consult your insurance regarding coverage for outpatient therapy in a hospital setting. We do check eligibility as a courtesy but your failure to check could result in an unpaid bill.******

St.Francis
EMORY HEALTHCARE

Name:	Date:	Gender:	DOB:
Email:	Cell Phone:		

CURRENT INJURY: ____

Date started?
Describe the onset and history of current condition _______________________________________ _______________________________________
Occupation?
□ Full Time □ Retired □ Not employed □ Part Time □ Disabled □ Modified □ Full or Part Time Student

Please rate your current pain (0 = no pain)

0 1 2 3 4 5 6 7 8 9 10

Over the past 6 months, have you been diagnosed with or are you currently experiencing any of the following symptoms?

□ Abnormal Bleeding	□ DVT/ blood clot	□ Multiple Sclerosis
□ Abuse □ Neglect	□ Falls to the ground	□ Muscle Cramps
□ Angina (chest pain)	□ Fibromyalgia	□ Heart Attack □ Heart Disease
□ Anxiety	□ Frequent UTI	□ Numbness
□ Arrythmia	□ Gastroesophageal reflux dis.	□ Osteoarthritis
□ Asthma	□ Glaucoma	□ Osteoporosis
□ Bipolar Disorder	□ Gout	□ Psoriatic Arthritis
□ Blood Clotting Disorder	□ Hard of hearing □Hearing aid	□ PVD(Peripheral Vascular Dis)
□ Bowel Incontinence	□ Hepatitis □ B □ C	□ Rheumatoid Arthritis
□ Cancer Type:	□ Hiatal Hernia	□ Scoliosis
□ Cellulitis	□ High Blood Pressure □ Low	□ Seizure Disorder
□ Closed Head Injury	□ High Cholesterol	□ Shortness of Breath
□ Colitis	□ HIV/AIDS	□ Sleeping Disorder
□ Congestive Heart Failure	□ Hypothyroidism □ Hyper	□ Tuberculosis □Current □ Past
□ COPD	□ Irritable Bowel Syndrome	□ Urinary Incontinence
□ Chron's Disease	□ Kidney Stones	□ Allergies: ________________:
□ CVA (stroke)	□ Liver or gallbladder issues	**FEMALE:**
□ Depression	□ Lymphedema	□ Currently Pregnant
□ Diabetes Type1 □ Diabetes 2	□ Migraine Headaches	□ Regular Menstrual Cycle
□ Dizziness □Clumsiness	□ MRSA	□ Menopausal symptoms

Please list any other symptoms or conditions not listed:

____

Have you had any of the following procedures?

□ Bypass Surgery □ Pacemaker □ Joint Replacement
□ Cardiac Ablation □ Stent Placement □ Metal Implants

Please list your current medications, vitamins or supplements. *(If your medications are written down, please allow us to scan into your chart)* ***Please specify blood thinners and NSAID's***

____

____

____

Please list any major surgeries (past 5 years) ***or pertinent to current condition***

____

____

Please list any diagnostic tests you've had performed ***specific to current condition***

□ Biopsy □ EMG □ Swallow Study
□ Blood work/Lab Tests □ Lower GI Study □ Upper Endoscopy
□ Bone Density Scan □ Motility Study □ Ultrasound
□ CT Scan □ MRI □ X-Ray
□ EEG □ Nerve Conduction Study □ Other

Living Situation

□ Single Story Home □ Ground Floor Apartment □ Assisted Living Facility
□ 2 Story Home □ Upper Level Apartment □ Skilled Nursing Facility
Are there stairs at home? □ Yes □ No Is there a handrail present? □ Yes □ No
□ Other situation Comment:

Who do you live with?

□ Spouse □ Child(ren) □ Alone
□ Spouse + Children □ Other Family Member □ Other
Are those checked available to help if needed? □ Yes □ No Comment: ____________________

What is your primary role at home?

□ Caregiver for others □ Housework □ Yard Maintenance
□ Financial Provider □ Home Maintenance □ Other
Is the patient currently able to perform these roles? □ Yes □ No Comment: ________________

Social Habits:

Smoker/Tobacco Use? □ Yes □No Packs/day:	□Frequently □Occasionally □ Rarely □Never	Past Smoker? □ Yes □ No Year stopped?
Do you consume alcohol?	□Frequently □Occasionally □ Rarely □Never	Drinks/week? Drinks/time?
Do you consume caffeine? □ Coffee □ Soda □ Energy drinks		Drinks/day___ Days/wk ___
Current or Prior Exercise Program?		Frequency/Duration?

Signed ______________________________________ Date ____________________

Relationship to Patient: ______________________________________

Witnessed By: ______________________________________

COVID-19/Coronavirus Medical History Addendum

Thank you for coming in today. As you know, the world is experiencing an expanding outbreak of respiratory illness (COVID-19) caused by a new coronavirus.

We take our role in protecting the health of our patients and staff very seriously. Before entering our facility, we respectfully ask you to ***confirm the following:***

Any Fever of ≥100°F or feeling of fever?	NO	YES
Cough?	NO	YES
Shortness of breath?	NO	YES
Chills or repeated shaking with chills?	NO	YES
Muscle Pain?	NO	YES
Headache?	NO	YES
Sore throat?	NO	YES
New loss of taste or smell?	NO	YES
Contact with people known to be COVID-positive?	NO	YES

Additional Comments: ____

____

____

Please reach out to a staff member if you have any questions or concerns.
Thank you for allowing us to take care of you!

Patient Name: ____

Signature: ____

Date: ______________________

St. Francis

We care for life.

AUTHORIZATION FOR MEDICAL TREATMENT FOR OUTPATIENT REHABILITATION

1. **Consent for Treatment & Authorization**

   I do herby consent for treatment at St. Francis Hospital for this treatment and subsequent treatments.

2. **Notice of Privacy Practices**

   I acknowledge that I understand the Hospital's Private Practices or I been given a copy per my direct request. I understand that this directly follows the HIPPA Privacy Act and if I have any questions or complaints I may contact the Hospital's Privacy Officer.

3. **Financial Agreement**

   A. In consideration of the services to be rendered, the undersigned (as parent, guardian, spouse, guarantor, agent or as the patient) individually promises to pay the patient account at the rates stated in the Hospital's Charge Master effective on the date the charge is processed for service provided, which rates are hereby expressly incorporated by reference as the price term of this agreement to pay the patients account. In the event the Hospital has to engage an attorney or collection agency to collect any unpaid balances that arise from the treatment consented to herein, the undersigned agrees to pay the reasonable attorney's fees and collection expenses incurred by the Hospital. This facility does bill through the hospital as an outpatient service and not an office visit. Your benefits should be verified in accordance because this could affect your co-pay and/or deductable. It is the patient's responsibility to verify benefits before time of service. We do check eligibility as a courtesy but the patient's failure to check could result in an unpaid bill and the patient being held accountable in full.

   B. **I acknowledge that I understand if my insurance changes at anytime during my treatment I am to notify St. Francis Rehab Center's Staff. If I fail to do so, I understand that I am responsible for all charges incurred during my treatment.**

   ☐ **YES, EVERYTHING IS THE SAME** with my insurance since my last authorization for medical treatment was signed.

   ☐ **NO, MY INSURANCE IS NOT THE SAME, there have been changes** since my last authorization for medical treatment was signed and I have informed the staff as of current date: ____________________.

4. **Release of Information**

   I acknowledge that the Hospital will use my information for the purposes of treatment, payment, and health care operations.

   I authorize the Hospital and any physician involved in my care to release medical information and supporting documentation of same as complied in my medical records during this admission or outpatient visit to any organization which 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 the Hospital to release any information from my medical records to my employers and/or its designee.

I hereby certify and state that I have read, and that I fully understand the Conditions of Treatment and that I have signed the appropriate areas of this authorization for medical treatment from knowingly, freely, and voluntarily. Moreover, I certify and state that I have received no promises, assurances, or guarantees from anyone as to the results that may be obtained by and treatment or services.

☐ Patient is medically unable to sign the Authorization of Treatment

Reason patient is unable to sign:______________________________

X____
PATIENT SIGNATURE (or authorized individual)

x_________________________________
DATE & TIME

x____
WITNESS

Rev 8/11

CONSENT FOR SERVICES AND FINANCIAL RESPONSIBILITY

Please read carefully and sign the necessary authorizations, releases and agreements so that we may proceed with the care and treatment ordered by your physician.

1. **CONSENT TO HOSPITAL SERVICES:** I understand that a patient's care is directed by his/her attending physician(s) and I consent to any hospital services that are appropriate for my care and as ordered by my physician(s).

2. **MEDICAL EDUCATION:** I understand that residents, interns, medical students, nursing or other students and trainees may observe, examine, treat and participate, with supervision, in my care as part of medical education programs.

3. **PATIENT'S CERTIFICATION AND PAYMENT REQUEST:** I certify that the information given by me in applying for payment under Title XVIII or XIX of the Social Security Act (Medicare) is correct. If I am a recipient of Medicare, I understand that I am responsible for the Medicare deductible, the co-insurance, life-time reserve days, if applicable, and the 20% Part B co-insurance for professional charges. I hereby irrevocably assign payment of all hospitalization and medical benefits applicable and otherwise payable to me to the hospital and to all clinical providers providing care to me at the hospital. Unless otherwise stated in the insurance contract, precertification is ultimately a patient responsibility.

4. **FINANCIAL AGREEMENT:** I, the undersigned, in consideration of the services to be rendered to the patient, am obligated to promptly pay the hospital in accordance with the charges listed in the hospital's charge description master and, if applicable, the hospital's charity care and discount payment policies and state and federal law. The hospital may provide, upon my request, a reasonable estimate of charges for items and services based on the hospital's charge description master. If any account is referred to an attorney or collection agency for collection, I agree to pay reasonable attorney's fees and collection expenses. I understand that, as a courtesy to me, the Hospital may bill my insurance company or health benefit plan, but is not required to do so. I agree and understand that, except where prohibited by law, the financial responsibility for the services rendered belongs to me, the undersigned. I further understand that the obligation to pay the hospital may not be deferred for any reason, including pending legal actions against other parties to recover medical costs. The Hospital shall determine whether and when an account is in default due to non-payment of the balance on the account. I understand that all physicians and surgeons, including the radiologist, pathologist, emergency physician, anesthesiologist, hospitalist, and others, will bill separately for their services.

5. **HOSPITAL TO ACT AS AGENT:** I irrevocably assign and transfer to the hospital all rights, benefits, and any other interests in connection with any insurance plan, health benefit plan (including an employer-sponsored health benefit plan), or other source of payment for my care. This assignment shall include assigning and authorizing direct payment to the hospital of all insurance and health plan benefits payable for this hospitalization or for these outpatient services. I agree that the insurers or plan's payment to the hospital pursuant to this authorization shall discharge its obligations to the extent of such payment. I understand that I am financially responsible for charges not paid according to this assignment, to the extent permitted by state and federal law. I agree to cooperate with and take all steps reasonably requested by this hospital to perfect, confirm, or validate this assignment. I also hereby authorize the Hospital, or the Hospital's designee, to act on my behalf in any dispute with a managed care organization, government health program, any insurance plan or any employer-sponsored health benefit plan with respect to benefits available under such plan. This authorization specifically includes the authorization to file any appeal on my behalf from a denial of benefits and to act as my agent in pursuing such appeals.

6. **CONSENT TO WIRELESS TELEPHONE CALLS AND TEXT MESSAGES:** If at any time I provide a wireless telephone number at which I may be contacted, I consent to receive calls or text messages, including but not restricted to communications regarding billing and payment for items and services, unless I notify the hospital to the contrary in writing. In this section, calls and text messages include but is not restricted to pre-recorded messages, artificial voice messages, automatic telephone dialing devices or other computer assisted technology, or by electronic mail, text messaging or by any other form of electronic communication from the hospital, affiliates, contractors, servicers, clinical providers, attorneys or its agents including collection agencies.

7. **CONSENT TO EMAIL USAGE:** If at any time I provide an email address at which I may be contacted, unless I notify the hospital to the contrary in writing, I consent to receiving discharge instructions, statements, bills, marketing material for new services and payment receipts at that email address from the hospital.

8. **OUTPATIENT MEDICARE PATIENTS:** Medicare does not cover prescription drugs except for a few exceptions. Per Medicare regulations you are responsible for any drugs furnished you while an outpatient that meet Medicare's definition of a prescription drug. These drugs are commonly referred to as self-administered drugs, as they are typically self-administered but can be administered by hospital personnel. Medicare requires hospitals to bill Medicare patients or other third party payers for these drugs. Medicare Part D beneficiaries may bill Medicare Part D for possible reimbursement of these drugs in accordance with Medicare Drug plan enrollment materials.

9. **INFECTION CONTROL CONSENT:** To protect against possible transmission of blood borne diseases, such as Hepatitis or Human Immunodeficiency Virus (AIDS. HIV), I understand it may be necessary or medically indicated to test my blood while I am a patient of the hospital if, for example, a hospital employee Is stuck by a needle while drawing blood, is splashed with blood, or sustains a scalpel injury and is exposed to my blood. I understand my blood, as well as the employee's blood will be tested for possible infection with the above mentioned diseases. The test results of both employee and patient will be kept confidential as provided by law.

10. **RELATIONSHIP BETWEEN HOSPITAL AND PHYSICIANS AND OTHER HEALTH CARE PROVIDERS:** I understand that most or all of the health care providers performing services in this Hospital are independent contractors and are not Hospital employees, representatives or agents. Most physicians and surgeons providing services to me, including the radiologist, pathologist, emergency physician, anesthesiologist, hospitalist and others, are independent contractors and are not employees, representatives or agents of the hospital. Likewise, most physician assistants (PA's), Nurse Practitioners (NP's), and Certified Registered Nurse Anesthetists (C.R.N.A.'s) are independent contractors and are not employees, representatives or agents of the hospitals. Independent contractors are responsible for their own actions and the Hospital shall not be liable for the acts or omissions of any such independent contractors. I understand that I may ask a Hospital employee, representative or agent to verify whether a particular health care provider is a Hospital employee or an independent contractor.

    Initials of patient / patient representative ______________________________

    I understand that I am under the care and supervision of my attending physician. The hospital and its nursing staff are responsible for carrying out my physician's instructions. My physician or surgeon is responsible for obtaining my informed consent, when required, to medical or surgical treatment, special diagnostic or therapeutic procedures, or hospital services provided to me under my physician's general and special instructions.

    I understand that physicians providing care at this hospital may be NON-PARTICIPATING providers in my insurance plan and will bill me for their professional services separately from the Hospital bill.

11. **ELECTION TO ELECTRONICALLY TRANSMIT MEDICAL INFORMATION AT ADMISSION, TRANSFER, OR DISCHARGE:** I authorize Hospital to provide a copy of the medical record of my treatment, the discharge summary, and a summary of care record to my primary care physician(s), specialty care physician(s), and/or any health care provider(s) or facility (ies) identified on my discharge paperwork to facilitate my treatment and continuity of care. I understand that information disclosed under this paragraph may include, among other things, confidential HIV-related information and other information relating to sexually transmitted or communicable diseases, information relating to drug or alcohol abuse or drug or alcohol dependence, mental or behavioral health information (excluding psychotherapy notes), genetic testing information, and/or abortion-related information. The summary of care record consists of information from my medical record, including among other things, information concerning procedures and lab tests performed during this admission, my care plan, a list of my current and historical problems, and my current medication list. I understand that I may, by placing my request in writing to the Privacy Officer, revoke this authorization at any time. However, I understand that a healthcare organization cannot take back information that has already been released under this authorization. This authorization will expire automatically one year after the date on which my current treatment episode comes to an end.

12. **ELECTION TO PARTICIPATE IN HEALTH INFORMATION EXCHANGE(S)**: I hereby authorize Hospital to provide a copy of my medical record or portions thereof to any health information exchange or network with which Hospital participates and to any other participant in such health information exchange or network for purposes of treatment, payment, and health care operations and in accordance with the terms of the participation agreement for that health information exchange or network. A full list of health information exchanges and/or network with which Hospital participates may be found in the Notice of Privacy Practices, which is available on the Hospital website, and this list may be updated from time to time if and when Hospital participates with new health information exchanges or networks. Hospital participates in the LifePoint health information exchange, which is operated by business associates of Hospital identified in the Notice of Privacy Practices, including LifePoint Corporate Services General Partnership. I understand that information disclosed under this paragraph may include, among other things, confidential HIV-related information and other information relating to sexually transmitted or communicable diseases, information relating to drug or alcohol abuse or drug or alcohol dependence, mental or behavioral health information (excluding psychotherapy notes), genetic testing information, and/or abortion-related information. I understand that I may, by placing my request in writing to the Privacy Officer, revoke this authorization at any time. However, I understand that a healthcare organization cannot take back information that has already been released under this authorization. This authorization will expire upon revocation.

13. **NOTICE OF PRIVACY PRACTICES:** I understand and have been provided with a Notice of Privacy Practices that provides a more complete description of my health care information uses and disclosures.

14. **PATIENT DIRECTORY PREFERENCE:** I have been informed that unless I object, the hospital can use a facility directory to inform visitors or callers, if they ask for me by name, about my location in the facility and general medical condition. Clergy may also receive this information as well as my religious affiliation.

    ☐ I object to having my name, location and general condition listed in the facility directory.

15. **ELECTION TO REQUEST INTERPRETIVE SERVICES:** In accordance with Sect. 60, of Title VI, the Hospital is committed to ensuring that all patients receive equal access to medical care. To achieve this goal, interpretive services may be utilized or requested at no cost to you.

16. **PATIENT RIGHTS:** I have received a copy of the Patient Rights. I understand these rights and if I have further questions, I will ask the nursing staff.

17. **CONSENT TO PHOTOGRAPH:** I consent to photographs, video or other images where deemed medically necessary by my physician before, during, or after a procedure. This is to provide documentation of my treatment and medical condition and will be kept as a part of my medical record.

18. **ADVANCE DIRECTIVE ACKNOWLEDGMENT:** I understand that I am not required to have an Advance Directive in order to receive medical treatment at this health care facility. I understand that the terms of my Advance Directive that I have executed will be followed by the health care facility and my caregivers to the extent permitted by law.

    ☐ I have executed an Advance Directive

    ☐ I have not executed an Advance Directive

    ☐ I would like to formulate an Advance Directive and receive additional information

19. **OTHER ACKNOWLEDGEMENTS:**

    a. Personal Valuables: I understand that I am responsible for all my personal effects, including personal grooming articles, clothing, eyeglasses, contact lenses, hearing aids, dentures, other prosthetic devices, electronic devices such as cell phones, laptops, electronic readers, iPads/Pods and all other such devices. I understand and agree that the hospital maintains a safe for the safekeeping of money and other valuables; however, except as required by law, the hospital is not liable for any loss or damage to property that is secured in the safe.

    b. Smoke Free Facility Policy: The Hospital is a smoke free facility. I understand that while I am a patient at the Hospital I may not use tobacco products.

    c. Weapons / Explosives / Drugs: I understand and agree that the hospital is a weapons, explosives, illegal substance or drug and alcohol free facility. I understand that while I am a patient at the Hospital I may not have these items in my room or with my belongings. If the hospital believes I have any of the above mentioned items the hospital may search my room and belongings. If found, the items may be confiscated, disposed appropriately or turned over to the law enforcement authorities.

    d. I understand and agree that recording or videoing Saint Francis staff without their explicit permission is not allowed.

20. **MATERNITY PATIENT:** If I deliver an infant(s) while a patient of this hospital, I agree that each provision of this Consent for Services, to include drug screening, and Financial Responsibility applies to the infant(s).

I have read and fully understand this Patient Consent and Financial Agreement and been given the opportunity to ask questions. I acknowledge that I either have no questions or that my questions have been answered to my satisfaction.

____ ____________________

Signature of Patient, Legal representative for health care Hospital Services if other than Patient — Date Time

__________________________ ____

Relationship of Representative — Reason Individual is Unable to Sign, i.e., Minor or Legally Incompetent

____ ____________________

Signature of Witness — Date Time

St. Francis

EMORY HEALTHCARE

Consent for Services and Financial Responsibility

Missed Appointment Policy

The Bradley Center of St. Francis, St. Francis Cardiothoracic and Vascular Institute, St. Francis Chattahoochee Valley Cardiology, St. Francis Center for Digestive Disorders, St. Francis Center for Surgical Care, St. Francis Columbus Clinic, St. Francis Columbus Specialty Clinic, St. Francis Electrophysiology Group, St. Francis ENT, St. Francis GYN Oncology, St. Francis Interventional Pain Management, St. Francis Neurology, St. Francis OBGYN Associates, St. Francis OBGYN Physician Partners, St. Francis Orthopaedic Institute, St. Francis Psychiatrists, St. Francis Wellness Center, St. Francis Wound Care & Hyperbaric Center, St. Francis Urology, St. Francis Rehabilitation Centers

The St. Francis Medical Group recognizes that your appointment time is reserved especially for you. In order to maintain an efficient and orderly practice, we ask that you give our office 24-hour notice if you are unable to attend a scheduled appointment. This 24-hour notice must be provided by the patient or their representative by either of the following methods:

A. In person at our office front desk.
B. Telephonically by calling the office appointment line.

Your assistance in this process will allow other patients in need of medical care and waiting for a cancellation to be notified.

We understand that situations may arise that are beyond your control and a 24-hour advance notice may not be possible. However, in these situations, we ask that you notify the office as soon as possible.

The office will charge a $50.00 missed appointment fee for any appointment missed without a 24-hour notice.

Patients who schedule and fail to keep three (3) appointments within a 12-month period may be dismissed from the practice.

Please know, your cooperation with the appointment policy will support our office in our shared effort to better serve your health and wellness and that of the community we serve.

Thank you.

I have read the above statement and agree to abide by the policy as stated above.

Patient or Representative Name (Print): ______________________________

Patient or Representative Name (Signature):______________________________

Date:____________________

Notice of Privacy Practices

This notice describes how medical information about you may be used and shared and how you can get access to this information. Please review it carefully.

Your rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Provide us a written request to have your paper or electronic medical record corrected
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information. This is a list of certain disclosures other than treatment payment or healthcare operations where authorization was not required
- Get a copy of this privacy notice
- Choose someone to act for you

Your choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition if they are involved in your care and treatment or ask about you by name
- Notify your primary care physician of services provided to you at the hospital
- Provide disaster relief
- Include you in a hospital directory unless you ask us not to
- Provide mental healthcare
- Market our services and sell your information with your permission or utilize it for fundraising purposes

Our uses & disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Seek payment for services provided to you
- Help with public health and safety issues
- Do research
- Comply with the law*
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Respond to requests from workers' compensation, law enforcement and other government agencies
- Respond to lawsuits and legal actions

* For more information, request an expanded version of our privacy policy.

Organized Health Care Arrangement (OHCA)

This notice applies to all service areas of St. Francis Hospital as well as the doctors and other healthcare providers practicing at this facility who are part of our organized health care arrangement (OCHA). It also applies to:

St. Francis Anesthetists, The Bradley Center of St. Francis, St. Francis Cardiothoracic and Vascular Institute, St. Francis Chattahoochee Valley Cardiology, St. Francis Center for Digestive Disorders, St. Francis Center for Surgical Care, St. Francis Columbus Clinic, St. Francis Columbus Specialty Clinic, St. Francis Electrophysiology Group, St. Francis ENT, St. Francis Hospital GYN Oncology, St. Francis Interventional Pain Management, St. Francis Neurology, St. Francis OBGYN Associates, St. Francis OBGYN Physician Partners, St. Francis Orthopaedic Institute, St. Francis Psychiatrists, St. Francis Radiologists, St. Francis Spine Center, St. Francis Urgent Care-Midtown, St. Francis Wellness Center, St. Francis Wound Care & Hyperbaric Center, St. Francis Wound Care Physician, Southwestern Pathology Associates, The Elena Diaz-Verson Amos Center for Breast Health, Health Matters of St. Francis.

We are required by law to protect the privacy of your information and notify you of certain breaches of your information. We are providing this notice to you so that we can explain our privacy practices. We will follow the practices described in this notice or the current notice in effect. We reserve the right to change our policies and notice of privacy practices at any time. If we should make a significant change, we will revise this notice and post a new one. You can also request a paper copy of our notice at any time.

Complaints
To file a complaint or report a concern or conflict, call the number listed below:

St. Francis Hospital

(706) 596-4124

If you prefer to report an anonymous concern, you may call **1-877-508-LIFE (5433).** You also may send a written complaint to the United States Department of Health and Human Services (HHS) if you feel we have not properly handled your complaint. You can use the contact listed above to provide you with the appropriate HHS address. Under no circumstance will you be retaliated against for filing a complaint.

For More Information
Ask any patient registration representative to receive a comprehensive, detailed summary of our privacy practices.

2122 Manchester Expy., Columbus, GA 31904
706-596-4000

Notice of Privacy Practices

St. Francis

St. Francis Hospital Billing Information

Thank you for choosing St. Francis Hospital for your healthcare needs.

We do bill through St. Francis Hospital as a facility not as an office visit. This may affect your co-pay and/or deductable.

They will file your claim and all insurance carriers that you have provided to us. You should not receive a billing statement from us for up to 30 days after all insurance has paid or rejected. You will receive a phone call and a billing statement to pay your balance due and/or to make payment arrangements. If you require an itemized statement, one will be provided upon request.

WE ASK THAT ALL CO-PAYS, DEDUCTIBLES AND CO-INSURANCE AMOUNTS BE PAID AT THE TIME YOUR SERVICES ARE PROVIDED. WE ACCEPT CASH, CHECKS OR CREDIT/DEBIT CARDS.

It is your sole responsibility to verify your benefits before the time of service. We do check eligibility as a courtesy but the patient's failure to check could result in an unpaid bill and the patient being held accountable in full for all services rendered. If you have any questions about your coverage please stop by or call our office at anytime for assistance at 706-256-0825 or call our billing office at 706-596-4412.

If you do not have insurance coverage, a summary statement will be sent to you after all medical record requirements have been met. If you need assistance in paying your bill, you may contact our hospital's financial counselor @ 800-866-3329. You will receive 3 statements in 30 day increments with the last being a FINAL NOTICE, unless you contact us to make financial arrangements. You may also be contacted via a telephone call for payment notification, and to help set-up payment arrangements, if needed. If you require an itemized statement, one will be provided upon your request.

COLUMBIA-SUICIDE SEVERITY RATING SCALE

Screen Version - Recent

SUICIDE IDEATION DEFINITIONS AND PROMPTS	**Past month**	
Ask questions that are bolded and underlined.	**YES**	**NO**
Ask Questions 1 and 2		
1) *Have you wished you were dead or wished you could go to sleep and not wake up?*		
2) *Have you actually had any thoughts of killing yourself?*		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.		
3) *Have you been thinking about how you might do this?* E.g. "*I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it....and I would never go through with it.*"		
4) *Have you had these thoughts and had some intention of acting on them?* As opposed to "*I have the thoughts but I definitely will not do anything about them.*"		
5) *Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?*		

6) *Have you ever done anything, started to do anything, or prepared to do anything to end your life?*	**YES**	**NO**
Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.		
If YES, ask: *Was this within the past three months?*		

- Low Risk
- Moderate Risk
- High Risk

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