Independence Health System

PATIENT INFORMATION

(PLEASE PRINT)

Date:_____ Account #:_____

Patient's Name:_____ Social Security Number:_____

Address:_____ Age:_____ Birthdate:_____

City/State/Zip:_____ Male/Female:_____

Family Doctor:_____ Home Phone:_____

Cell Phone:_____

If Patient is a minor, Person Responsible for Account

Guarantor's Name:_____ Referred By:_____

Guarantor's DOB:_____ Patient Status: Single__ Married__ Other__

Address:_____ Employed:__ PT Student__ FT Student__

City/State/Zip:_____ Patients Employer:_____

Phone#_____ Address:_____

Relationship to Patient:_____ City/State/Zip Code:_____

Parent or Spouse Employer:_____ Phone:_____ Occupation:_____

Social Security Number:_____

Relative to Contact In the Event of Emergency

Name:_____Phone:_____Relationship_____

Address:_____City/State/Zip_____

REASON FOR VISIT:_____

*Payment is expected upon completion of visit.

How will you be paying today? ( ) Cash/Check ( ) Mastercard ( ) Visa

If you have any questions or anticipate problems with payment, please see the receptionist upon completion of the form.

Please specify whom you may want protected health information released to other than yourself:

_____

_____

_____

(over)

Excela Health Medical Group - Authorization Form

CONSENT FOR TREATMENT

This is to certify that I, the undersigned, hereby consent to and authorize the administration and performance of all diagnostic procedures and/or such medical, surgical, lab or x-ray treatment, which in the judgement of my attending physician or his authorized agent, may be considered necessary or advisable. I also authorize release of information to the Poison Center if required as part of my treatment.

RELEASE OF INFORMATION

I authorize Excela Health Medical Group to release to other parties including, but not limited to, insurance companies, claims processors, my primary care physician and other physicians and caregivers, information regarding my treatment, hospitalization and/or outpatient care, which may include mental health care, drug abuse and/or alcoholism, Sickle Cell Anemia, Acquired Immunodeficiency Syndrome (AIDS), or tests for diagnosis of Human Immunodeficiency Virus (HIV).

I understand this information may be requested for the purpose of continuing care, billing, worker's compensation and/or employee health. This may include all or part of my medical record,

I understand, I may revoke this authorization at any time by written request except for information already disclosed.

AUTHORIZATION OF PAYMENT

I hereby authorize payment directly to Excela Health Medical Group for the insurance benefits otherwise payable to me but not to exceed the balance. I understand I am financially responsible to the Excela Health Physician Practices for charges not covered by my insurance.

MEDICAL ASSISTANCE INFORMATION

I understand that payment and satisfaction of the claim that I am incurring will be from Federal and State funds, and that any false claims, statements or documents or concealment of material facts, may be prosecuted under applicable federal or state laws. I am also aware that there are certain deductible/copayments on most Medical Assistance services and that I am liable to pay these deductible/copayments to the above-named providers.

STATEMENT TO PERMIT PAYMENT OF MEDICARE BENEFITS TO PROVIDER (PHYSICIAN)

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services or its intermediaries or carriers any information needed to determine these benefits for related services. I request payment be made directly to the provider for authorized Medicare benefits for me, or on my behalf for any services furnished to me by the Excela Health Medical Group, including physician services. I request that payment of authorized MEDIGAP benefits be made either to me or on my behalf to Excela Health Medical Group for any services furnished to me by that physician/supplier. I authorize any holder of Medicare information about me to release to Health Care Financing Administration or its agents, any information needed to determine these benefits payable for related services.

SELF PAY

I understand that I am financially responsible to Excela Health Medical Group for all charges.

RELEASE OF CELL PHONE NUMBER

I HEREBY AUTHORIZE Excela Health Medical Group or any entity utilized by Excela Health Medical Group to contact me via cell phone for purposes of obtaining payment for services provided to me during this episode of care. I understand these calls may be pre-recorded or made using auto-dialing technology.

Signature of Patient/Insured: _____ **Date:** _____

Patient's Agent or Representative: _____ **Date:** _____
(indicate relationship)

Staff Signature: _____ **Site:** _____ **Date:** _____

MEDICAL HISTORY

Name _____ **Age** _____ **Birthdate** ___/___/_____

Phone: Please indicate your preferred contact number by checking the appropriate box.

☐ **Home** _____ ☐ **Work** _____

☐ **Cell** _____ ☐ **Email** _____

Sex: ☐ Male ☐ Female

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated

Children: Please list names and ages.

_____

_____

☐ **Established Patient** ☐ **New Patient**

Pharmacy(s)

Name	Address
_____	_____
_____	_____
_____	_____

Past Medical History

Please indicate if you have/had any of the following conditions:

☐ Acid Reflux
☐ Alcohol Abuse
☐ Anxiety
☐ Arthritis
☐ Asthma
☐ Cancer (Type_____)
☐ Chronic Bronchitis
☐ Congestive Heart Failure
☐ COPD
☐ Depression
☐ Diabetes (Please circle: Type I or II)
☐ Emphysema
☐ Gout
☐ Heart Disease
☐ Heartburn
☐ High Blood Pressure
☐ High Cholesterol
☐ Kidney Disease
☐ Migraines
☐ Severe Headaches
☐ Sexually Transmitted Disease
☐ Stroke
☐ Thyroid problems
☐ Tobacco Use
☐ Tuberculosis
☐ Other _____

Surgical History

Please list any surgeries and the year they occurred.

Surgery/Year	Surgery/Year
_____	_____
_____	_____
_____	_____
_____	_____

NOTE: This form is not part of the medical record. Shred 30 days after entered into the EHR.

Allergies

Do you have any allergies to medications, IV dyes, or other substances? □ Yes □ No

If 'yes,' please list them below and tell us your reaction.

Medication/Substance	Reaction
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Family History

Please indicate if a blood relative (parents, grandparents, siblings, children) has/ had any of the following conditions. Please list the type of relative in the right column.

	Blood Relative
Alcohol Abuse	_____
Anxiety	_____
Arthritis	_____
Asthma	_____
Cancer (Type_____)	_____
Congestive Heart Failure	_____
COPD	_____
Depression	_____
Diabetes (Type ____)	_____
GERD	_____
GI problems	_____
Gout	_____
Heart Disease	_____
High Cholesterol	_____
Hypertension	_____
Kidney Disease	_____
Migraines	_____
Nicotine Dependence (Smoker)	_____
Severe Headaches	_____
Sexually Transmitted Disease	_____
Stroke	_____
Thyroid problems	_____
Tuberculosis	_____

Other _____

Please let us know…

Are you or have you ever been a victim of abuse or neglect? _____

Do you use alcohol? □ Yes □ No Number of drinks/week? ____

Do you use, or have you ever used, recreational drugs? □ Yes □ No What type? _____

Do you exercise regularly? _____ Number of times/week _____

Do you drink caffeine? _____

Do you have an advanced directive? □ Yes □ No If No, would you like information on AD? □ Yes □ No

What is your occupation? _____

If you are retired, what was your occupation when you were working? _____

Are you currently unemployed? _____

Do you smoke? _____ How many packs a day? _____ For how long? _____

_____

Reviewer Signature/Date

NOTE: This form is not part of the medical record. Shred 30 days after entered into the EHR. Rev 6/15/12

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.

Certain healthcare operations of Excela Health participate in Health Information Exchanges.

Excela Health is required by law to keep your health information private and to inform you of our legal duties and privacy practices with respect to your health information. Please reference the "Health Information Exchange Standard" below for more information.

Who follows this notice?

Excela Health provides easy access to a full range of services to meet your health care needs. The privacy practices described in this notice are followed by the employees, doctors, other professionals and volunteers who serve you at any of our locations including:

- *Frick Hospital, Latrobe Hospital, and Westmoreland Hospital* [including off-campus services]
- *Excela Square at Norwin* [Norwin Medical Commons]
- *CareGivers of Southwestern PA* [including behavioral health outreach services]
- *Excela Health Home Care & Hospice*
- *Excela Health Medical Group*
- *Laurel Surgical Center*
- *MedCare Equipment Co. LLC*
- *The Latrobe Area Hospital Charitable Foundation and Westmoreland/Frick Hospital Foundation*

How we may use or disclose your health information

The Excela Health mission is "improving the health and well-being of every life we touch." We respect the privacy of your health information, including demographic, financial and medical information. We may use or disclose your health information for:

- *Treatment provided to you*. Example: Your health information may be accessed by anyone directly or indirectly involved in your care at Excela Health or provided to other health care providers as necessary for referral, consultation, continuing treatment and/or the provision of other treatment-related healthcare services. *This includes* notifying the relevant members of your care team such as your primary care physician or specialists that treat you of your admission to or discharge or transfer from one of our hospital facilities as long as such care team members can be identified.
- *Payment sought for services provided to you*. Examples: Your insurance company may require or request health information about you to pay a claim; we may provide health information to other providers to enable them to bill for services they provide you.
- *Health care operations*. Examples: We may review health information in an effort to maintain or improve quality, comply with health care regulations and/or insurance provisions, review or approve doctor privileges, coordinate your continued care needs, or seek legal representation regarding potential claims.
- We may share your health information with a business associate that supports our operations. Examples: An independent auditor billing company; electronic medical record software company; copying service, etc.
- We may contact you to schedule or remind you about appointments, or to notify you of other treatments, services, health care products, or events we support that may be of interest to you.
- We may contact you for our fundraising activities. You have a right to opt out of receiving fundraising communications.
- Federal law permits use or disclosure of your health information *without* obtaining individual authorization for certain administrative activities of Excela Health that are necessary and/or required. These activities include reports: of public health activities to public health agencies such as the state or federal government (e.g., disease/injury reports, births, deaths, child abuse or neglect, adverse events); to employers in certain situations (e.g., for workplace medical or injury/illness evaluation); of victims of abuse, neglect or domestic violence; for health oversight activities authorized by law (e.g., audits, inspections); for legal or administrative proceedings (e.g., compliance reviews, court orders); to law enforcement; about decedents (e.g., coroner, medical examiner, funeral director); about organ donation; for workers' compensation benefits, and for research when an approved authorization waiver is obtained.
- We will obtain your oral approval or objection for use and disclosure of your health information for: involving family or friends in your care, and listing your name, location, general condition and religion in our facility directory when you are in the hospital. The information in our facility directory may be disclosed to clergy or other people who ask for you by name. It could also be disclosed to a disaster relief agency to inform your family of your location and condition. You have the right to restrict or deny the use and disclosure of your health information for these purposes. In an emergency, when we cannot obtain your oral approval or objection, we will use professional judgment in the use or disclosure of your health information for these purposes.
- Other uses and disclosures not described in this notice will be made *only with your written authorization. Examples: Psychotherapy notes, for marketing purposes, or the sale of your protected health information*. You may revoke such authorization by informing us in writing of your request.

What are your rights regarding your health information?

- *Requesting restrictions on use and disclosure* ~ You have the right to request that we restrict the use and disclosure of your health information for treatment, payment or health care operations, or for purposes that require your oral approval or objection as previously noted. We are not required to agree to a requested restriction.
- *Restricting certain disclosures of your health information to a health plan when you paid out of pocket in full for the health service or item.*
- *Receiving confidential communications related to your health information* ~ You have the right to specify other ways or locations you receive confidential communications from Excela Health about your health information.
- *Accessing and copying your health information* ~ In most cases, you have the right to review or get a copy of your health information maintained by Excela Health. In a few instances, we can deny access. If we deny access, we will inform you in writing. If you request a copy of your health information, we may charge a fee for the cost of copying and mailing this information to you.
- *Requesting corrections in your health information* ~ You may ask that we amend any of your health information if you believe it to be incorrect or incomplete. You must give us the reason why you are asking for the change. We may deny your request if the information was not created by Excela Health, is not part of your medical record maintained by Excela Health, or if we find that the information is accurate and complete. If we deny your request, we will inform you in writing. You have the right to respond to us if you do not agree with the denial.
- *Receiving a list of disclosures* ~ You may ask for a list of disclosures of your health information that relate to *non-routine purposes where your written authorization is not required*. Examples: public health activities, legal proceedings, law enforcement, etc. We are not required to list disclosures related to treatment, payment and health care operations; facility directory listings; involvement of family or friends in your care; correctional institutions, or any disclosure for which you gave your written authorization.
- *Receiving notice that your health information was breached* ~ If your health information was accessed, used or disclosed due to a breach of unsecured protected health information, we will notify you promptly of the occurrence and provide you with details regarding the information that was breached.
- *Requesting a paper copy of this notice* ~ You may request a paper copy of this notice from the physician office, registration clerk, or Customer Service Department. You may also obtain this notice through our website at www.excelahealth.org.

You may exert any of these rights by informing us in writing of your request.

What are our duties with respect to this notice and your health information?

We are required to follow the privacy practices described in this notice as of the effective date. We have the right to change our notice and apply any new privacy practices to any of your health information that we maintain. We will make the revised notice available on its effective date. You may receive a revised notice by requesting one during your visit.

HEALTH INFORMATION EXCHANGE STANDARD

Excela Health ("Provider") participates in the ClinicalConnect Health Information Exchange (HIE).

Excela Health ("Provider") participates in the CommonWell Health Information Exchange (HIE).

An HIE is an organization that providers, payers, and providers of ancillary healthcare related services participate in (each a "Participant") to exchange patient information in order to facilitate health care, avoid duplication of services (such as tests) and to reduce the likelihood that medical errors will occur. By participating in the HIE, Excela Health may share your health information with Participants or participants of other health information exchanges. The health information includes, but is not limited to:

- Test Results. By example, General laboratory tests, Pathology tests, Radiology tests, GI tests, cardiac tests, neurological tests, etc.
- Health Maintenance documentation
- Problem lists
- Allergy Information
- Immunizations
- Medication lists
- Consultation and Progress notes
- Discharge summaries and instructions
- Clinical Claims Informations

Ancillary healthcare related service providers may include, but are not limited to:

- Organ Procurement
- Diagnostic Testing
- Pharmacies
- Durable medical Equipment Suppliers
- Home Health Services

All Participants have agreed to a set of standards relating to their use and disclosure of health information available through the HIE. These standards are intended to comply with all applicable state and federal laws.

As a result, you understand and agree that unless you notify your Provider that you do not wish for your health information to be available through the HIE ("Opt-Out"), your information will be shared.

- Health information that results from any Participant providing services to you will be made available through the HIE. For clarity, if you Opt-Out, your health information will no longer be accessible through the HIE. However, your opt-out does not affect health information that was disclosed through the HIE prior to the time that you opted out;
- Regardless of whether you choose to opt-out of the HIE, your health information will still be provided to the HIE. However, if you choose to Opt-Out, the HIE will not exchange your health information with other providers and payers. Additionally, you cannot choose to have only certain providers or payers access your health information;
- All Participants who provide services to you will have the ability to access and download your information. However, Participants that do not provide services to you will not have the ability to access or download your information;
- Information available through the HIE may be provided to others as necessary for referral, consultation, treatment and/or the provision of other treatment-related healthcare services to you. This includes providers, payers, pharmacies, laboratories, etc.;
- Your information may be disclosed for payment related activities associated with your treatment by a Participant and your information may be used for healthcare operations related activities by Participants.

You may Opt-Out at any time by notifying Excela Health.

A list of Participants may be found at:

ClincialConnect: www.clinicalconnecthie.com

CommonWell: https://www.commonwellalliance.org/who-is-connected

How can you contact us or complain about our privacy practices?

If you want to make a written request regarding your protected health information, or think we may have violated your privacy rights and want to file a complaint, please contact the Excela Health Customer Service Department at:

Excela Health Customer Service
532 West Pittsburgh Street
Greensburg, PA 15601
Phone: 724-830-8566

You have the right to send a written complaint to the United States Department of Health and Human Services Office for Civil Rights. We will not take retaliatory action against you if you file a complaint about our privacy practices.

Excela Health
Medical Group

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE

I acknowledge that I received the Notice of Privacy Practices for Excela Health System and Excela Health Medical Group -includes all Excela Health primary care and specialist offices.

Please indicate each method of communication Excela Health may use to contact you in regards to your health information and upcoming appointments.

☐ Messages may be left on my home answering machine.

☐ Messages may be left on my work voicemail.

☐ Messages may be left on my cell phone.

☐ Information may be released only to me and not be left by any electronic method.

_____
Name of Patient

_____ _____
Signature of Patient (or patient's personal representative) Date of receipt

Personal representative information (if applicable):

_____
Name of personal representative

_____
Relationship to patient (or other authority)

EXCELA HEALTH MEDICAL GROUP
AGREEMENT TO PARTICIPATE
SURESCRIPTS PHARMACY SERVICES

I _____ agree to the participation with Surescripts pharmacy services in providing and coordinating electronic prescription transmittal service between Excela Health Medical Group and the pharmacy I select.

I understand the purpose of this agreement is to allow my physician to access my medication history through Surescripts. I understand this agreement will remain in effect for as long as I seek medical care with Excela Health Medical Group, and it will terminate should I transfer my care, request termination of this agreement or after a period of three years without activity with this pratice.

_____ _____
Patient Signature Date/Time

_____ _____
Witness Signature Date/Time

Patient Name_____

MR # _____

or Patient Sticker Only

EXCELA HEALTH/EXCELA HEALTH MEDICAL GROUP
Authorization for Third Party Disclosure

Patient Name: _____ Date of Birth: _____ / _____ / _____
Address: _____ City: _____ State: _____ Zip: _____
Email Address: _____ Phone: _____
_____ Request for copies of Record _____ Access to view record electronically

Entity to Release the records:

☐ **Westmoreland Hospital** ☐ **Latrobe Hospital** ☐ **Frick Hospital**

☐ **EHMG Office:** _____ ☐ **Other:** _____

I, _____ **, authorize the entity selected above to disclose health information as described below**
(Patient Name)

regarding my treatment, hospitalization, and/or care for my condition, which may include psychiatric impairment, drug abuse and/or alcoholism, sickle cell anemia, sexually transmitted diseases or Acquired Immunodeficiency Syndrome (AIDS) or tests for or infection with Human Immunodeficiency Virus (HIV) to:

Recipient Name: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Email Address: _____
Fax (Healthcare provider only): _____
Purpose of Disclosure: _____

I authorize the following information to be released from my medical record:
Date(s) of service: _____
Hospital (circle): Discharge Summary, History & Physical, Consultation, Operative Report, Pathology Report, Lab Results,
Diagnostic Testing (specify) _____, Radiology Report, Film/Image, Emergency Dept. Report,
Entire Record, Other (specify) _____
Physician Office (circle): Office Notes, Consultation, Health Maintenance, History, Lab Results, Radiology Results,
Other (specify) _____
Disclosure Format (Paper is default if not marked): Email (secure format) _____
_____ US Mail - paper format _____ CD/Flash Drive (secure format) _____ Fax (Healthcare provider only)
_____ Other (please specify): _____

- I understand that the information described above could possibly be redisclosed by the recipient and no longer protected by the federal privacy regulations. The recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.
- I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing as described in the Excela Health Notice of Privacy Practices. I understand that the revocation will not apply to information that has already been used or disclosed in response to this authorization. I understand that the revocation will not apply if the authorization was related to my obtaining insurance coverage, as the insurer has the right by law to contest a claim or insurance policy. Unless otherwise revoked, this authorization will expire on the following date or event : _____. If I fail to specify an expiration date or event, **this authorization will expire in one year.**
- I understand that Excela Health/Excela Health Medical Group may not condition treatment, payment, enrollment or eligibility for benefits on signing this authorization except in the case of research-related treatment.
- I understand that I can request a copy of this completed authorization form.

_____
Signature of Patient/Customer or Legal Representative Date/Time

_____
If signed by Legal Representative, Relationship to Patient/Customer

_____
Signature of Witness Date/Time

VERBAL AUTHORIZATION (for persons physically unable to sign)
Not applicable to HIV or Drug & Alcohol Treatment Information. I witness that the patient understood the nature of this release and freely gave their oral authorization. (2 witnesses required)

Witness #1_____ Date/Time_____

Witness #2_____ Date/Time_____

7680021

Printed Name of Employee Fulfilling Request _____

Title:_____