Date: _____

Chart #:_____

Name: _____ Age: _____

(First) (Maiden or Middle Initial) (Last)

Date of Birth: _____ Social Security # or Driver License #:_____

_____Single _____Married _____Widowed _____Divorced _____Separated

Address: _____ Apt #:_____

City: _____ State: _____ Zip: _____-_____

Main Phone #: (_____) _____-_____ Other Phone #: (_____) _____-_____

Employer: _____ Position: _____

Work Phone #: (_____) _____-_____ May we call you at work? _____ Yes _____No

How did you hear about our office? Referred by doctor or friend_____;
Telephone Directory _____; Billboard _____; Commercial _____; Website _____;
Magazine or Newspaper Ad _____; Other_____ (Please specify)

Complete this Section if Married

Husband's Name: _____

Social Security # or Driver License #: _____ Date of Birth: _____

Employer: _____ Position: _____

Emergency Contact

Name: _____ Relationship:

_____

Address: _____

Street City State Zip

Phone #: (_____) _____-_____

Complete if a Minor

Parent's Name: _____

Address: _____

Street City State Zip

Phone #: (_____) _____-_____ Employer: _____

PLEASE GIVE THE RECEPTIONIST YOUR INSURANCE CARD(S) TO COPY.

ALL CHARGES ARE PAYABLE AT THE TIME SERVICES ARE RENDERED. We do not accept assignment on all insurances, so please check with the business office PRIOR to seeing the provider if you have any questions about your financial responsibility. Thank you for your cooperation.

Patient Name: _____ Chart#: _____
First Middle Initial Last

Patient's Date of Birth: _____ Patient's Social Security # or Driver License #_____

HIPPA Privacy Notice Acknowledgement

I have read the Notice of Privacy Practices for Columbus ObGyn Specialty Center. I understand that I may ask questions if I do not understand any part of the notice. I may also request a copy of the notice for my personal records.

_____ _____
Signature of Patient **Date**

Authorization for Disclosure of Private Health Information to Family/Friend

I hereby authorize Gregory W. Childrey, M.D., Clay B. Hudson, M.D., and their staff to discuss my private health information, to include the results of my medical tests such as pap smears, biopsies, exam findings, etc., and the need for further treatment based on the findings of such tests, with the following person(s):

Name	**Relationship**
_____	_____
_____	_____
_____	_____

I understand that because the person(s) receiving this information is/are not a health plan(s) or health care provider(s) covered by federal privacy regulations, the information may be disclosed by the recipient(s) and may no longer be protected by federal or state law.

I understand that I may revoke this authorization at any time by notifying Columbus ObGyn Specialty Center in writing and that if I choose to do so, my request to revoke will not affect any actions by Columbus ObGyn Specialty Center before receiving my revocation.

_____ _____
Signature of Patient **Date**

Authorization Denied to Disclose Private Health Information to Family/Friend

I am not a minor, and I do NOT want my private health information to be disclosed to any family member or friend. I understand that my refusal will not affect my treatment, payment, or eligibility for benefits.

_____ _____
Signature of Patient **Date**

Payment Policy

It is the policy of Columbus ObGyn Specialty Center that payment is due at the time services are provided. It is the patient's responsibility to check with the business office prior to being seen if you have any questions regarding fees, insurance information, etc. All outstanding balances must be paid in their entirety before any additional services will be provided by any provider employed at Columbus ObGyn Specialty Center.

Self-Pay

All self-pay patients are responsible for payment of their entire account at the time services are provided. For scheduled surgeries performed in the hospital, payment is due when the patient gets her preoperative orders. If a non-scheduled surgery is performed, payment is due immediately following discharge. If the entire balance cannot be paid at once, arrangements must be made with the business office immediately.

***Medicare**

Dr. Childrey is a NONparticipating provider with Medicare. Therefore, Medicare beneficiaries are responsible for payment of all services received in the office the day the service is provided. We will collect the limiting charge that is set by Medicare, and you will only be reimbursed 80% of that amount after your deductible has been met. Medicare will send this payment directly to you. Medicare will then cross your claim over to your supplemental carrier, and if a payment is due, it will be made directly to you also.

Medicaid

The providers of this clinic do participate with Mississippi Medicaid and UnitedHealthCare Community Plan of the MississippiCAN Program. If a patient has Medicaid, they must present their card before services are provided. All applicable copays are due at the time services are rendered. If the Medicaid is not in effect at the time of service, you are responsible for payment. If Medicaid becomes effective and you qualify for "retroactive eligibility", our office WILL NOT bill Medicaid for those services and REFUND the beneficiary.

Private Insurance

The providers of this clinic do not participate with all private insurances, and it is the patient's responsibility to check with the business office prior to being seen if you have any questions regarding your coverage here. For those insurances that we do not accept, the patient is responsible for payment in full at the time of the service, and we will give you a form that you can file with your insurance carrier to receive your benefits. For those insurances that we do accept, the patient is responsible for payment as outlined by their plan. Therefore, office copays, deductibles, and coinsurance amounts are due at the time of service. After the insurance has paid, the patient is responsible for any remaining balance. If payment arrangements need to be made, you must contact our business office immediately.

We are participating providers for the following networks:
BCBS of Mississippi, BCBS of Alabama, State Employees Network,
MPCN (Mississippi Physicians Care Network), Baptist Network,
UnitedHealthCare, Cigna, and Tricare (Standard and Prime).

If you have any questions about your insurance, ask someone in our business office prior to being seen by the provider. We will gladly assist you in finding out what your benefits are for the services provided in our clinic. It is the patient's responsibility, not the employees of Columbus ObGyn Specialty Center, to know your benefits, and ultimately it is the patient's responsibility for payment of their accounts.

I have read the above payment policy and understand my financial responsibility as a patient. I know that I can ask someone in the business office about my financial obligations prior to services being provided if I have any questions.

_____ _____

Patient's Signature or Parent/Guardian (if a minor) Date

Patient Name: _____ Chart#:_____

(First) (Maiden or Middle Initial) (Last)

ASSIGNMENT OF BENEFITS AUTHORIZATION

I hereby authorize Columbus ObGyn Specialty Center to furnish information to insurance carriers concerning my illness and treatments, including office/progress notes, surgical reports, laboratory and pathology results, and any other information necessary to process claims filed. I hereby assign to the provider(s) all payments for medical/surgical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by my insurance if assignment was taken.

_____ _____

Signature of Patient or Guardian/Parent (if a minor) Date

NONDISCRIMINATION POLICY

Columbus ObGyn Specialty Center does not discriminate against any person on the basis of race, color, national origin, disability, or age in admission, treatment, or participation in its programs, services, and activities, or in employment.

COMMUNICATION WITH PERSONS OF LIMITED ENGLISH PROFICIENCY (LEP) AND FOR PERSONS WITH IMPAIRED HEARING, VISION, OR SPEECH

Columbus ObGyn Specialty Center will provide communication aids (at no cost to the person being served) to Limited English Proficient (LEP) persons and to persons with impaired hearing, vision, or speech, who wish to be patients here at our practice. If any of these resources are needed, please notify our office PRIOR to the day of your appointment so that arrangements can be made. Our contact number is 662-240-0095.

_____ _____

Signature of Patient or Guardian/Parent (if a minor) Date

Insurance Information

Patient Name: _____ Date of Birth: _____

Previous and/or Maiden Name(s): _____

Address: _____

City, State, Zip: _____

Primary Phone #: _____ Secondary Phone #:_____

Social Security # or Driver License #: _____

Primary Insurance:
Insurance Company Name: _____

Claims Address: _____

City, State, Zip: _____

Insured's Name: _____

Policy #: _____ Group/Plan #: _____

Secondary Insurance:
Insurance Company Name: _____

Claims Address: _____

City, State, Zip: _____

Insured's Name: _____

Policy #: _____ Group/Plan #: _____

*If anything is sent to pathology (i.e. pap smear, biopsy, etc.), a copy of this form will go to the lab so that they can file your insurance. You will receive a separate bill from that facility for any balance that your insurance does not pay.

Notice of Privacy Practices

Effective Date: August 15, 2013

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

If you have any questions about this notice, please contact our privacy officer:

Tiffany East
425 Hospital Dr, Suite 5
P.O. Box 8700
Columbus, MS 39705
(662-240-0095)

1. **Summary of Rights and Obligations Concerning Health Information**. Columbus ObGyn Specialty Center, PLLC is committed to preserving the privacy and confidentiality of your health information, which is required both by federal and state law. We are required by law to provide you with this notice of our legal duties, your rights, and our privacy practices, with respect to using and disclosing your health information that is created or retained by Columbus ObGyn Specialty Center, PLLC. Each time you visit us, we make a record of your visit. Typically, this record contains your symptoms, examination and test results, our assessment of your condition, a record of your treatment interventions, and a plan for future care or treatment. We have an ethical and legal obligation to protect the privacy of your health information, and we will only use or disclose this information in limited circumstances. In general, we may use and disclose your health information to:

- plan your care and treatment;
- provide treatment by us or others;
- communicate with other providers such as referring physicians;
- receive payment from you, your health plan, or your health insurer;
- make quality assessments and work to improve the care we render and the outcomes we achieve, known as health care operations;
- make you aware of services and treatments that may be of interest to you; and
- comply with state and federal laws that require us to disclose your health information.

We may also use or disclose your health information where you have authorized us to do so.

Although your health record belongs to Columbus ObGyn Specialty Center, PLLC, the information in your record belongs to you. You have the right to:

- ensure the accuracy of your health record;
- request confidential communications between you and your provider and request limits on the use and disclosure of your health information; and
- request an accounting of certain uses and disclosures of health information we have made about you.

We are required to:

- maintain the privacy of your health information;
- provide you with notice, such as this Notice of Privacy Practices, as to our legal duties and privacy practices with respect to information we collect and maintain about you;

• abide by the terms of our most current Notice of Privacy Practices;
• notify you if we are unable to agree to a requested restriction; and
• accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all your health information that we maintain.

Should our information practices change, a revised Notice of Privacy Practices will be available upon request. If there is a material change, a revised Notice of Privacy Practices will be distributed to the extent required by law. We will not use or disclose your health information without your authorization, except as described in our most current Notice of Privacy Practices. In the following pages, we explain our privacy practices and your rights to your health information in more detail.

2. We may use or disclose your medical information in the following ways:

A. Treatment. We may use and disclose your protected health information to provide, coordinate and manage your care. That may include consulting with other health care providers about your health care or referring you to another health care provider for treatment including physicians, nurses, and other health care providers involved in your care. For example, we will release your protected health information to a specialist to whom you have been referred to ensure that the specialist has the necessary information he or she needs to diagnose and/or treat you.

B. Payment. We may use and disclose your health information so that we may bill and collect payment for the services that we provided to you. For example, we may contact your health insurer to verify your eligibility for benefits, and may need to disclose to it some details of your medical condition or expected course of treatment. We may use or disclose your information so that a bill may be sent to you, your health insurer, or a family member. The information on or accompanying the bill may include information that identifies you and your diagnosis, as well as services rendered, any procedures performed, and supplies used. Also, we may provide health information to another health care provider, such as an ambulance company that transported you to our office, to assist in their billing and collection efforts.

C. Health Care Operations. We may use and disclose your health information to assist in the operation of our practice. For example, members of our staff may use information in your health record to assess the care and outcomes in your case and others like it as part of a continuous effort to improve the quality and effectiveness of the healthcare and services we provide. We may use and disclose your health information to conduct cost-management and business planning activities for our practice. We may also provide such information to other health care entities for their health care operations. For example, we may provide information to your health insurer for its quality review purposes.

D. Students. Students/interns in health service related programs work in our facility from time to time to meet their educational requirements or to get health care experience. These students may observe or participate in your treatment or use your health information to assist in their training. You have the right to refuse to be examined, observed, or treated by any student or intern. If you do not want a student or intern to observe or participate in your care, please notify your provider.

E. Business Associates. Columbus ObGyn Specialty Center sometimes contracts with third-party business associates for services. Examples include answering services, computer software support, consultants, and legal counsel. We may disclose your health information to our business associates so that they can perform the job we have asked them to do. To protect your health information, however, we require our business associates to appropriately safeguard your information.

F. Appointment Reminders. We may use and disclose Information in your medical record to contact you as a reminder that you have an appointment. We usually will call you at the home and/or the cell phone numbers provided the day before your appointment and leave a message for you on your answering machine or with an individual who responds to our telephone call. However, you may request that we call you only at a certain number or that we refrain from leaving messages and we will endeavor to accommodate all reasonable requests.

G. Treatment Options. We may use and disclose your health information in order to inform you of alternative treatments.

H. Release to Family/Friends. Our staff, using their professional judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, your health information to the extent it is relevant to that person's involvement in your care or payment related to your care. We will provide you with an opportunity to object to such a disclosure whenever we practicably can do so. We may disclose the health information of minor children to their parents or guardians unless such disclosure is otherwise prohibited by law. However, please note that under Mississippi state law, if a child age eighteen (18) or older requests that their medical information not be disclosed to a parent or guardian, we must comply with their request. Also please note that under Mississippi state law, if a child is pregnant, regardless of age, she can request that her medical information not be disclosed to a parent or guardian, and we must comply with the request. Please let your provider know if you would not like us to release information to a family member or friend.

I. Health-Related Benefits and Services. We may use and disclose health information to tell you about health-related benefits or services that may be of interest to you. In face- to-face communications, such as appointments with your provider, we may tell you about other products and services that may be of interest you.

J. Letters and Other Communications. We may use your personal information in order to communicate to you letters through the mail or other means regarding treatment options, health related information, disease management programs, wellness programs, or other community based initiatives or activities in which our practice is participating.

K. Disaster Relief. We may disclose your health information in disaster relief situations where disaster relief organizations seek your health information to coordinate your care, or notify family and friends of your location and condition. We will provide you with an opportunity to agree or object to such a disclosure whenever we practicably can do so.

L. Marketing. In most circumstances, we are required by law to receive your written authorization before we use or disclose your health information for marketing purposes. Under no circumstances will we sell our patient lists or your health information to a third party without your written authorization.

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

- licensing and certification carried out by public health authorities;
- prevention or control of disease, injury, or disability;
- reports of births and deaths;
- reports of child abuse or neglect;
- notifications to people who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- organ or tissue donation; and

• notifications to appropriate government authorities if we believe a patient has been the victim of abuse, neglect, or domestic violence. We will make this disclosure when required by law, or if you agree to the disclosure or when authorized by law and in our professional judgment disclosure is required to prevent serious harm.

N. Food and Drug Administration (FDA). We may disclose to the FDA and other regulatory agencies of the federal and state government health information relating to adverse events with respect to food, supplements, products and product defects, or post-marketing monitoring information to enable product recalls, repairs, or replacement.

O. Research. We may disclose your health information to researchers when the information does not directly identify you as the source of the information or when a waiver has been issued by an institutional review board or a privacy board that has reviewed the research proposal and protocols for compliance with standards to ensure the privacy of your health information.

P. Workers Compensation. We may disclose your health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Q. Law Enforcement. We may release your health information:

• in response to a court order, subpoena, warrant, summons, or similar process of authorized under state or federal law;
• to identify or locate a suspect, fugitive, material witness, or similar 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 Columbus ObGyn Specialty Center, PLLC;
• to coroners or medical examiners;
• 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;
• to authorized federal officials for intelligence, counterintelligence, and other national security authorized by law; and
• to authorized federal officials so they may conduct special investigations or provide protection to the President, other authorized persons, or foreign heads of state.

R. De-identified Information. We may use your health information to create "de-identified" information or we may disclose your information to a business associate so that the business associate can create de-identified information on our behalf. When we "de-identify" health information, we remove information that identifies you as the source of the information. Health information is considered "de-identified" only if there is no reasonable basis to believe that the health information could be used to identify you.

S. Personal Representative. If you have a personal representative, such as a legal guardian, we will treat that person as if that person is you with respect to disclosures of your health information. If you become deceased, we may disclose health information to an executor or administrator of your estate to the extent that person is acting as your personal representative.

T. Limited Data Set. We may use and disclose a limited data set that does not contain specific readily identifiable information about you for research, public health, and health care operations. We may not disseminate the limited data set unless we enter into a data use agreement with the recipient in which

the recipient agrees to limit the use of that data set to the purposes for which it was provided, ensure the security of the data, and not identify the information or use it to contact any individual.

U. Military and Veterans. If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

3. Authorization for Other Uses of Medical Information. Uses of medical information not covered by our most current Notice of Privacy Practices or the laws that apply to us will be made only with your written authorization. You should be aware that we are not responsible for any further disclosures made by the party you authorize us to release information to. If you provide us with authorization to use or disclose medical information about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose medical information about you for the reasons covered by your written authorization, except to the extent that we have already taken action in reliance on your authorization or, if the authorization was obtained as a condition of obtaining insurance coverage and the insurer has the right to contest a claim or the insurance coverage itself. We are unable to take back any disclosures we have already made with your authorization, and we are required to retain our records of the care that we provided to you.

4. Your Health Information Rights. You have the following rights regarding medical information we gather about you:

A. Right to Obtain a Paper Copy of This Notice. You have the right to a paper copy of this Notice of Privacy Practices at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy.

B. 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. This includes medical and billing records.
To inspect and copy medical information, you must submit a written request to our privacy officer. We will supply you with a form for such a request. If you request a copy of your medical information, we may charge a reasonable fee for the costs of labor, postage, and supplies associated with your request. We may not charge you a fee if you require your medical information for a claim for benefits under the Social Security Act (such as claims for Social Security, Supplemental Security Income, and any other state or federal needs-based benefit program).

C. 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 we retain the information. To request an amendment, your request must be made in writing and submitted to our 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 Columbus ObGyn Specialty Center, PLLC;

- is not part of the information which you would be permitted to inspect and copy; or
- is accurate and complete.

If we deny your request for amendment, you may submit a statement of disagreement. We may reasonably limit the length of this statement. Your letter of disagreement will be included in your medical record, but we may also include a rebuttal statement.

D. Right to an Accounting of Disclosures. You have the right to request an accounting of disclosures of your health information made by us. In your accounting, we are not required to list certain disclosures, including:

- disclosures made for treatment, payment, and health care operations purposes or disclosures made incidental to treatment, payment, and health care operations. However, if the disclosures were made through an electronic health record, you have the right to request an accounting for such disclosures that were made during the previous 3 years;
- disclosures made pursuant to your authorization;
- disclosures made to create a limited data set;
- disclosures made directly to you.

To request an accounting of disclosures, you must submit your request in writing to our privacy officer. Your request must state a time period which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you would like the accounting of disclosures (for example, on paper). The first accounting of disclosures you request within any 12 month period will be free. For additional requests within the same period, we may charge you for the reasonable costs of providing the accounting of disclosures. We will notify you of the costs involved and you may choose to withdraw or modify your request at that time, before any costs are incurred. Under limited circumstances mandated by federal and state law, we may temporarily deny your request for an accounting of disclosures.

E. 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, payment, or health care operations. If you paid out-of-pocket for a specific item or service, you have the right to request that medical 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 are required to honor that request. You also have the right to request a limit on the medical information we communicate about you to someone who is involved in your care or the payment for your care.

Except as noted above, we are not required to agree to your request. If we do agree, we will comply with your request unless the restricted information is needed to provide you with emergency treatment. To request restrictions, you must make your request in writing to our privacy officer. In your request, you must tell us:

- what information you want to limit;
- whether you want to limit our use, disclosure, or both; and
- to whom you want the limits to apply.

F. 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 e-mail. To request confidential communications, you must make your request in writing to your provider or our 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.

G. Right to Receive Notice of a Breach. We are required to notify you by first class mail or by e-mail (if you have indicated a preference to receive information by e-mail), of any breaches of Unsecured Protected Health Information as soon as possible, but in any event, no later than 60 days following the

discovery of the breach. "Unsecured Protected Health Information" is information that is not secured through the use of a technology or methodology identified by the Secretary of the U.S. Department of Health and Human Services to render the Protected Health Information unusable, unreadable, and undecipherable to unauthorized users. The notice is required to include the following information:

- a brief description of the breach, including the date of the breach and the date of its discovery, if known;
- a description of the type of Unsecured Protected Health Information involved in the breach;
- steps you should take to protect yourself from potential harm resulting from the breach;
- a brief description of actions we are taking to investigate the breach, mitigate losses, and protect against further breaches;
- contact information, including a toll-free telephone number, e-mail address, Web site or postal address to permit you to ask questions or obtain additional information. In the event the breach involves 10 or more patients whose contact information is out of date we will post a notice of the breach on the home page of our Web site or in a major print or broadcast media. If the breach involves more than 500 patients in the state or jurisdiction, we will send notices to prominent media outlets. If the breach involves more than 500 patients, we are required to immediately notify the Secretary. We also are required to submit an annual report to the Secretary of a breach that involved less than 500 patients during the year and will maintain a written log of breaches involving less than 500 patients.

5. Complaints. If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the U.S. Department of Health and Human Services, 200 Independence Ave, S.W., Washington, D.C. 20201. To file a complaint with us, contact our privacy officer at the address listed above. All complaints must be submitted in writing and should be submitted within 180 days of when you knew or should have known that the alleged violation occurred. See the Office for Civil Rights website, www.hhs.gov/ocr/hipaa/ for more information. You will not be penalized for filing a complaint