A Northside Network Provider

English - Spanish

Full Name:_____ Date of Birth _____
(First) *(Middle)* *(Last)*

Gender (circle) Male Female **Marital Status (circle)** Single Married Divorced Widowed

Address_____City_____ State_____ Zip_____

*Preferred Phone Number ☐ home ☐ cell _____

*Email_____

Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown/Declined

Race ☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other ☐ Unknown/Declined

Preferred Language ☐ English ☐ Spanish ☐ Chinese(Cantonese) ☐ Chinese(Mandarin) ☐ French ☐ German ☐ Italian ☐ Japanese ☐ Portuguese ☐ Russian ☐ Other

Employer _____ Employer Phone_____

Preferred Communication for Appointment Reminders: ☐ Phone Call ☐ Automated Text ☐ Automated Email

Patient Agrees that Practice may also rely on patient's expressed preference when making the appointment

We require a minimum of 24 hour notice for cancellations. Failure to do so may result in a charge for the missed appointment.

Pharmacy Information

Pharmacy Name_____ Phone_____ Fax _____

Pharmacy Address _____

Guarantor if not the patient (financially responsible party for minor or incapacitated adult):

Name _____ Date of Birth _____Relationship to Patient_____

Address_____City_____ State_____ Zip_____

*Preferred Phone Number ☐ home ☐ cell_____ *Email _____

*By providing a phone number or email address, you understand that communication by email and text may be an unsecure form of communication and you expressly consent and authorize Northside and its affiliates to contact you via phone calls (through the use of any dialing equipment such as artificial or pre-recorded voice technology and/or automated telephone dialing systems), texts, and/or emails, including for appointment reminders, payment-related messages, quality improvement communications such as surveys, and invitations to join our secure patient portal, if available.

Emergency Contacts Information and Relationship to Patient:

Name _____ Relationship_____Phone_____

Name _____ Relationship_____Phone_____

Referring Physician Information:

Physician Name_____ Specialty _____Office Name_____

Address: _____ Phone_____ Fax _____

Primary Care Physician Information (if different than referring physician):

Physician Name_____ Specialty _____Office Name_____

Address: _____ Phone_____ Fax _____

Does your insurance require a referral? ____YES ____NO; **if yes,** please provide the referral to the receptionist

	Primary Insurance	**Secondary Insurance**
Name of Insurance		
Policy Holder Name and Date of Birth		
Policy Holder Relationship to Patient		
Policy/Member ID Number		
Group/Plan Number		

Patient/Guarantor Signature _____ **Date** _____

Reorder #26985 PP0001
Piedmont Graphics Rev. 03/17/2020

PATIENT REGISTRATION FORM

A Northside Network Provider

English - Spanish

Patient Name _____

Date of Birth _____ /_____ /_____
Month Day Year

FINANCIAL ACKNOWLEDGEMENT

ASSIGNMENT OF BENEFITS: Unless I have specified otherwise, verbally or in writing, in consideration of the services provided at Northside Hospital, I hereby assign and transfer to the Hospital and other medical providers all hospital and medical provider benefits payable under my insurance policies or benefit plans. I hereby assign and transfer all related rights and remedies due under the insurance policies or benefit plans that I have identified or will identify in connection with all services rendered, including but not limited to all rights and remedies pursuant to applicable state, federal and ERISA regulation. I hereby assign and transfer all rights to the Hospital and other medical providers applicable under ERISA, federal or state regulation to pursue any benefit denial, limitation of coverage or request for an administrative review of fiduciary duties involving administration of benefits by the U. S. Dept of Labor, the Department of Community Health or the Department of Insurance. I authorize and direct the insurance company to pay all such benefits to the Hospital and appropriate medical providers. I understand that assignment does not relieve me of any responsibility I may have for payment of charges not paid by the insurance company, unless otherwise provided by the terms of an agreement between the insurance company and the Hospital. If admission is for pregnancy, assignment of benefits will also apply to any newborn child. I certify that the information I have provided with respect to my coverage is true and accurate. I also understand that Northside Hospital may have to submit my health information for this or a related claim, including confidential information (i.e. mental health, alcohol/drug abuse or HIV/AIDS), for payment purposes. This assignment will remain in effect until revoked by me in writing.

PRECERTIFICATION: **I understand** that my insurance policy may require compliance with a utilization review program to make certain that health care benefit funds are expended when justified. **I understand** that it is the utilization review program's responsibility to review proposed elective admissions and anticipated courses of treatment. **I understand** that if the utilization review program determines that admission is necessary and appropriate and issues certification, the benefits of my health plan will be made available to me in accordance with the terms of my policy. However, if certification is denied, health care benefits may be withheld. **I understand** that precertification may be the responsibility of the patient or financially responsible party and his or her physician. **I understand** that Northside Hospital is willing to admit as requested by my physician. **I also understand** that I may be financially responsible for all hospital charges incurred as a result of admission should the utilization review program refuse to certify that the admission is appropriate, or should the certification effort occur too late to be valid. **I understand** that to protect myself from unnecessary personal financial losses, I must provide insurance coverage at time of registration, review my obligations with my insurance company, utilization review program, and personal physician without delay.

ABOUT YOUR BILLING:

Hospital and Provider-Based Services — In addition to a bill received from Northside Hospital, you may receive a bill for the professional component of treatment. Although Northside Hospital may be a provider in an insurance network, the physician or professional service group may or may not be a covered provider of service. Medicare and Medicare Advantage patients will receive a coinsurance liability estimate. If the care received is outpatient care, the insurance carrier will process the claim(s) on an outpatient basis. Outpatient services may require co-insurance, deductible and/or co-pay, depending on insurance policy benefits.

Physician Practice Locations — If services are received in a physician practice, which is not a provider-based outpatient location of Northside Hospital, insurance benefits will be processed as a physician office visit.

FINANCIAL RESPONSIBILITY: Payment in full is expected at the time services are received. Accounts more than 30 days past due will accrue interest at the rate of 8 percent annually. This interest does not apply to deductibles/copayments of Medicare/Medicaid or other governmental programs. **(Accounts under an agreed alternate payment contract will not be considered past due, provided the plan is accepted in writing in accordance with Northside Hospital's Payment Installment Agreement Plan up to one hundred eighty (180) days of service, depending upon the Payment Plan established, with all conditions of the payment plan met.)** Insured patients are required to pay identified co-pay,ated co-insurance prior to any elective services unless alternate arrangements are made. Uninsured patients are required to make payment in full prior to any elective services unless alternate arrangements are made. This provision does not apply, and payment will not be requested, prior to emergency screening and stabilizing treatment as required by federal law.

I authorize Northside Hospital, or any of its affiliates, agents, contractors or business associates, to contact me (by any telephone numbers, email addresses or other contact points provided by me or on my behalf) by the use of any automatic dialing system, by pre-recorded forms of voice/messaging systems, by electronic mail owned or used by the guarantor/responsible party, by telephone or by cell phone for reasons related to the services I received at Northside Hospital or payment for the services I received at Northside Hospital, including but not limited to, debt collection purposes. I further understand and acknowledge that my consent in receiving the aforementioned communications is not required nor is it a preceding condition to receiving health care services at Northside Hospital.

_____ I do not agree with the above statement and do not wish to be contacted by the use of any automatic dialing system; by pre-recorded forms of voice/messaging systems; by electronic mail or by receiving voice messages on my cell phone, except for clinical issues

By signing below, I acknowledge and agree that I have read or had this form read to me and I understand and agree to its contents.

_____ _____
Signature of Patient or Legal Representative Date/Time Relationship to Patient If Not the Parent

_____
Interpreter Signature Date/Time

Note: If phone/video interpretation used, record interpreter ID#

Interpreter comments (optional): _____

RECEIPT OF NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I acknowledge receipt of the Notice of Privacy Practices ("Notice") from Northside Hospital, Inc. and the Northside Hospital medical staff. The Notice provides information about how Northside Hospital and the Northside Hospital medical staff members may use and disclose my health information. I have been encouraged to read the Notice in full.

I understand that Northside Hospital and its Medical Staff members operate as an "organized health care arrangement" and have presented me with a joint notice of privacy practices. Although the Hospital and Medical Staff members have established an organized health care arrangement for purposes of complying with privacy laws, some or all of the health care professionals performing services in this hospital or its outpatient centers are not employees or agents of the Hospital and remain independent contractors. Independent contractors are responsible for their own actions and Northside Hospital shall not be liable for the acts or omissions of any such independent contractors.

I understand that the Notice is subject to change. If Northside Hospital changes the Notice, I may obtain a copy of the revised Notice at Northside's website (www.northside.com).

_____ _____
Signature of Patient or Legal Representative Date/Time Relationship to Patient If Not the Parent

_____
Interpreter Signature Date/Time

Note: If phone/video interpretation used, record interpreter ID#

Interpreter comments (optional): _____

INABILITY TO OBTAIN ACKNOWLEDGEMENT FOR RECEIPT OF PRIVACY PRACTICES

☐ **Patient/Representative refused to sign** ☐ **Patient not competent to sign and legal representative not present** ☐ **Other** _____

Reorder #26703 PP0004
Piedmont Graphics Rev. 01/18/2022

ANNUAL ACKNOWLEDGEMENT

A Northside Network Provider

English - Spanish

Name of Patient: _____ Phone #: _____ DOB: _____

Address: _____

Physician Practice Name: _____

The Northside Hospital Office Practice identified above is hereby authorized to (**Please mark appropriate box**):
☐ **Release to OR** ☐ **Receive from** the following person(s) or entity(ies) or class of person(s) or entity(ies) (**Please identify by name or general description and provide address, if known**): _____

_____

The following protected health information regarding the patient (**Please mark appropriate box(es)**): ☐ Complete Medical Record
☐ Abstract of Medical Record (physician dictated reports & diagnostic reports) ☐ Labs only ☐ Radiology only ☐ EKG only
☐ Other (**Please specify clearly**) _____

For the following dates of service: Start Date: _____ End Date: _____
In the following format: ☐ Paper ☐ Electronic **Need records certified:** ☐ Yes ☐ No
I understand that in some instances my medical record may also include my health information from other healthcare facilities owned and/or operated by Northside Hospital.

Unless you state otherwise, this authorization **includes** the release and disclosure of **all medical records and information,** including but not limited to, paper and electronic records, x-rays, films, and other documents, except as otherwise noted below. This authorization **includes** the release of any information regarding **treatment or referral for substance abuse, including drugs and alcohol**, except for patients treated for substance abuse at the Northside Hospital Behavioral Health Recovery Program. (See Page 2 for additional information). If you have received genetic testing, for example for the breast cancer gene, a different consent form is required.

Unless you state otherwise by marking one or both boxes below, this authorization **includes** the release and disclosure of records and information which may include (i) **HIV/AIDS** confidential information and/or (ii) **privileged mental health communications** between the patient and a mental healthcare provider, and **you affirmatively waive any protections from disclosure** that might otherwise apply. **HIV/AIDS confidential information** is defined by Georgia law to include the fact that a patient has had an HIV test or been counseled about HIV, even if the test is negative. **NOTE:** Unless otherwise permitted by law, the release of **HIV/AIDS** confidential information and/or **privileged mental health communications** can be authorized only by the patient or an individual who is legally authorized to make a living patient's healthcare decisions, including a legal guardian, health care agent, or parent of a minor.

☐ I **object** to the release of **HIV/AIDS** confidential information.
☐ I **object** to the release of any **privileged mental health communications** under Georgia law.

The purpose of the requested disclosure is: _____
I understand that my/ the patient's treatment at a Northside Hospital Physician Practice Office and/or Northside Hospital will not be affected if I refuse to sign this authorization. I also understand my right to revoke this authorization in writing at any time except to the extent that action has already been taken in reliance on it or if the authorization was provided as a condition of obtaining insurance coverage. **Note:** This authorization can be revoked by submitting a written request to the **Practice Coordinator at the Northside Hospital Physician Practice Office identified above.**

This authorization for the release of protected health information shall remain in effect until the **earlier** of any of the following dates:
(a)_____ **(in this blank, you may include a specific expiration date or event, such as conclusion of a lawsuit);** **(b)** the date I revoke this authorization in writing; or (c) three (3) years from the date on which I signed this authorization. If I signed this authorization on behalf of a minor, it will expire when the minor turns 18, marries or becomes emancipated under Georgia law.

Note: Please read BOTH SIDES of this form and complete all applicable lines below, with your signature, date and time. By signing this authorization, you affirmatively represent that (i) you are the patient OR (ii) the patient is alive and you are legally authorized to make his or her healthcare decisions, including the release of medical records.

_____
Witness

_____ AM/PM_____
Date Time

_____
Interpreter (if applicable)
Note to staff: if telephone interpretation provided, record name of company and interpreter ID number.

_____
Signature of Patient or Legally Authorized Representative,
Including Legal Guardian, Health Care Agent, or Parent of Minor Child

Print name: _____

Relationship to patient: _____

Reason patient unable to sign: _____

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS AND INFORMATION

White - Medical Records
Yellow - Patient

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS AND INFORMATION

Note: To authorize the disclosure of psychotherapy notes, the additional form entitled ***Authorization for Release of Psychotherapy Notes*** will need to be completed. To authorize the disclosure of patient records from the Northside Hospital Behavioral Health Recovery Program, the additional form entitled ***Authorization for Release of Alcohol and Drug Abuse Patient Records*** will need to be completed.

I understand the potential that medical records and information disclosed pursuant to this authorization in whatever form and/or means provided (including, but not limited to, electronic transmission, paper copies, CDs, films, and flash drives) may be subject to re-disclosure by the recipient and may no longer be subject to protections under the federal privacy laws and regulations. I further understand that any electronic format of my health information that I receive may not be encrypted or password protected and I am responsible for taking precautions to protect the data and storing it in a secure manner. By choosing to receive my health information electronically, I acknowledge and accept the risk of doing so. I hereby release the Northside Hospital Physician Office Practice, Northside Hospital, Inc., and their agents and employees from any and all liabilities, responsibilities, damages, and claims which might arise from the release, receipt, and/or re-disclosure of the medical records and information I have authorized above.

NOTICE TO RECEIVING AGENCY OR INDIVIDUAL

Disclosure or receipt of the information authorized above does not remove any privilege or right of confidentiality with respect to the information and does not authorize re-disclosure of the information. If any of the disclosed information relates to treatment or referral for treatment for substance abuse which is protected by Federal confidentiality rules (42 C.F.R. Part 2), the following notice shall also apply.

> **This information has been disclosed to you from records protected by Federal confidentiality rules (42 C.F.R. Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.**

A Northside Network Provider

English - Spanish

PATIENT'S NAME: _____ DATE OF BIRTH: _____

BY SIGNING BELOW I ACKNOWLEDGE AND AGREE THAT:

Consent To Routine Procedures. I consent to medical care and procedures while I am a patient at THIS MEDICAL PRACTICE OR ANY OTHER Northside Network Provider ("Practice"). This includes non-invasive testing or procedures, such as routine exams, needle sticks, physical assessments and treatments, administration of medications, drawing blood, bodily fluids or tissue samples, insertion of tubes, imaging procedures or physical therapy ("Routine Procedures") recommended by my physician or other provider. I also consent to minor procedures performed under local anesthesia, such as bone marrow aspiration or removal of skin tags. ("Minor Procedures.")

The Routine Procedures may be performed by physicians, nurses, technicians, physician assistants or other healthcare professionals The Minor Procedures are performed by a physician or qualified midlevel provider. While these Procedures are routinely performed without incident, there may be material risks associated with each. It is not possible to list every risk for every Procedure, but in rare circumstances, the procedures may cause infection, loss of limb or function, damage to tissue or implants, paralysis or death. If I have any questions or concerns regarding these Procedures, I will ask my physician for more information. If I do not consent to a procedure, I will tell my physician or other provider when they recommend the procedure.

Testing And Disposition Of Specimens, Devices, Foreign Objects. I consent to each Practice or any lab used by the Practice retaining any tissue specimens, medical devices or foreign objects removed, expelled or otherwise separated from my body. If tissue specimens include products of conception or fetal remains, they may be disposed of by the lab after necessary examination. I agree that these items may be examined by pathologists, used for scientific or teaching purposes, and disposed of or retained according to the discretion of the Practice or lab, unless I request otherwise in writing before the procedure. I will let the Practice know if I have other requests for handling specimens. Any items I do not retrieve within fourteen days after the Procedure will be disposed of.

Downloaded Prescription Records. Each Practice may download my medication history from pharmacies, health plans, and other healthcare providers and include it in my electronic medical record to improve the coordination of my medical care. This may include information about medications prescribed to me for mental health conditions, sexually transmitted diseases, substance abuse disorders, and HIV/AIDS. If I do not want the Practice to obtain this information, I will notify the Practice in writing. I understand that my written revocation of consent will not be effective until received and acknowledged by the Practice in writing and it will not have any effect on actions taken prior to such revocation. Refusal to allow downloading prescription records does not prevent my physician from viewing records under the Georgia Prescription Drug Monitoring Program for narcotics.

Testing For Blood-Borne Pathogens. Georgia law allows testing for blood-borne pathogens in certain situations. (1) If a health care worker is exposed to my blood (e.g., suffers a needle stick), my blood may be tested for diseases including HIV/AIDS. Additional information about this test is available. I will be informed of test results. (2) If I am an obstetrical patient in the third trimester of pregnancy, the Practice may test me for HIV and syphilis as required by Georgia law. (3) For all other patients, if my physician recommends an HIV test, he or she will notify me and I will have the right to refuse the test at that time. If I have questions about any laboratory testing, I will ask my physician about the purpose of the test and may refuse it at that time.

Students. The Practice is engaged in health care education. At times care, examination and treatment may be delivered by students under the supervision of a physician or other authorized Practice personnel. Students will never have primary responsibility for my care; there will always be fully licensed health care professionals supervising the students and available to assist me. If I do not want students to participate or observe my care, I will notify my physician or other care provider at the time of service.

Medications From Outside Source. I agree to notify the Physician about medicines (including supplements and herbal products) that I am taking and to follow the Physician's instructions. If I bring medicine to the Practice for administration, the Practice may examine it so that it can be documented on my record, but the Practice is not responsible for the safety or proper dispensing of medication.

Privacy, Individuals Involved In My Care. I understand that, unless I request confidentiality, the privacy laws allow the Practice to communicate with family members or others who may be involved in my care. I agree that the providers can communicate with me in the presence of family members or others who come with me to my appointment. If I object, I will notify my provider and ask my family to leave when the provider is discussing care with me.

Telehealth. I consent to telehealth consultations recommended by my physician. During the consultation, my medical history and test results may be discussed with Georgia licensed health professionals through telecommunication technology. In some cases, a physical exam will be performed. Unless I object, a non-medical technician may be present to assist with the technology and, audio or video recordings may be taken. I can withhold or withdraw consent to the telehealth consultation at any time without affecting my right to future care, or risking the loss of any Medicaid benefits to which I may be entitled. If I do not consent to a telehealth consultation, some services may not be available at all Northside locations. I have been informed of available alternative options which may include in-person services. All state and federal laws, including privacy and confidentiality, apply to records of the telehealth consultation. The consulting physician will inform me of any other risks or benefits of the telehealth consultation. I have the right to see appropriately trained staff in-person immediately after the telehealth consultation if an urgent need arises. By scheduling or participating in telehealth services, I am consenting to those services.

PHOTOGRAPHY AND RECORDING. Providers may take photographs or videotapes of patients for medical documentation or identification. Photographs and related information may be published in professional journals or medical books, or used for any similar purpose in the interest of medical education, knowledge or research; provided, however, that in any such publication or use, I will not be identifiable. No protected health information will be released without my consent.

NORTHSIDE HOSPITAL AFFILIATED MEDICAL PRACTICE
ANNUAL ACKNOWLEDGEMENT – CLINICAL ISSUES

Some or all of the health care professionals performing services at Network Provider offices are independent contractors and are not facility agents or employees. Independent contractors are responsible for their own actions and the facility shall not be liable for the acts or omissions of any such independent contractors.

BY SIGNING BELOW I ACKNOWLEDGE AND AGREE THAT:
The practice of medicine is not an exact science. No guarantees have been made to me as to the result of any treatment or examination in the Practice;
The healthcare professionals participating in my care will rely on my medical history and other information obtained from me, my family or others having knowledge about me, in determining whether to perform or recommend the Procedures; therefore, I agree to provide accurate and complete information about my medical history and conditions; I have been informed about and offered a copy of Northside's statement of rights and responsibilities;
I consent to participation in and assistance with the Procedure(s) by Practice employees, medical personnel under the direct supervision and control of the Physician, and other medical personnel involved in my care; and
If a health care worker is exposed to my blood as a result of care provided at this practice, my blood may be tested for HIV/AIDS

I have read or had all pages of this form read to me and understand its contents. All statements that I do not approve of were stricken before I signed this form. If I am signing this form on behalf of another person, to the best of my knowledge, I am legally authorized to consent on that person's behalf.

Witness Date/Time

Signature of Patient or Legal Representative Date/Time

Relationship to Patient If Not the Parent

Interpreter Signature Date/Time

Note: If phone/video interpretation used, record interpreter ID#

Interpreter comments (optional): _____

NOTICE OF NON-DISCRIMINATION

Northside Hospital complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. **ATTENTION:** If you speak a language other than English, language assistance services, free of charge, are available to you. Call 404-845- 5898(Atlanta/Forsyth) ; 678-493-1507 (Cherokee)

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

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 404-845-5898 (Atlanta/Forsyth) ; 678-493-1507 (Cherokee).

Northside Hospital tuân thủ luật dân quyền hiện hành của Liên bang và không phân biệt đối xử dựa trên chủng tộc, màu da, nguồn gốc quốc gia, độ tuổi, khuyết tật, hoặc giới tính.
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 404-845-5898 (Atlanta/Forsyth) ; 678-493-1507 (Cherokee)

YOUR RIGHTS AND RESPONSIBILITIES AS A PATIENT

English - Spanish

YOUR WELL BEING AND HEALING ARE OUR PRIMARY CONCERN. WE BELIEVE THAT A POSITIVE EXPERIENCE IS A RESPONSIBILITY THAT IS SHARED BY YOU AND YOUR HEALTH CARE PROVIDERS.

YOUR RIGHTS AS A PATIENT OF A NORTHSIDE AFFILIATED MEDICAL PRACTICE

- You have the right to request and receive information on patient rights, responsibilities and ethics.
- You have the right to considerate, and respectful care and compassionate medical care, regardless of your race, religion, national origin, any disability or handicap, gender sexual orientation, gender identity or expression, age, military service or the source of payment for your care.
- You have the right to an identified surrogate decision-maker, as allowed by law, when you cannot make decisions about your own care, treatment, and service.
- You, your family, and/or surrogate decision maker have the right, as appropriate and as allowed by law, to be involved in care, treatment, and service decisions, including the assessment and treatment of your pain.
- You have the right to request an environment that preserves dignity and contributes to a positive self-image.
- You have the right to request privacy and confidentiality as reasonable and appropriate under the circumstances.
- You have the right to communication that you understand, including qualified medical interpretation services and other reasonable accommodations, free of charge, if you have special communication needs due to vision, speech, hearing, language, or cognitive barriers or impairments.
- You have the right to request consultation with another physician or specialist, including a pain specialist.
- You and, when appropriate, your family have the right to be informed about the care you receive, including treatment, services and anticipated and unanticipated outcomes.
- You or your surrogate decision-maker have the right to accept or refuse medical or surgical treatment to the extent permitted by law, including for-going or withdrawing life-sustaining treatment or withholding resuscitative services, in accordance with law and regulation.
- You have the right to execute, review and revise an advance directive, and, upon admission to the hospital, receive information on the extent to which the organization is able, unable or unwilling to honor advance directives. (The existence or lack of an advance directive does not determine an individual's access to care, treatment and services.)
- You have the right to request access, request amendment to, and receive an accounting of disclosures regarding your own health information as permitted under applicable law, including current information concerning your diagnosis, treatment and prognosis (Health Information Portability & Accountability Act 1996).
- You and your family have the right to request an ethics consultation to assist in resolving any ethical issues, concerns or dilemmas regarding your care, treatment and services.
- You have the right to request to be considered as a candidate for organ/tissue/eyes donation.
- You have the right to have your wishes concerning organ donation honored, within the limits of the law or organizational capacity.
- You have the right to reasonable personal safety while you are a patient, including access to protective services, as allowable by law and as reasonable under the circumstances.
- You have the right to request to be informed of rules and regulations that apply to you as a patient, and to speak to a Patient Relations Representative to have complaints, suggestions for improvements or concerns heard.

- All patients have the right to be free from physical or mental abuse, and corporal punishment.
- All patients have the right to be free from restraint or seclusion, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff. Restraint or seclusion may only be imposed to ensure the immediate physical safety of the patient, a staff member, or others, and must be discontinued at the earliest possible time.
- You have the right to freely voice complaints and recommend changes without being subject to coercion, discrimination, reprisal, or unreasonable interruption of care, treatment, and services.
- You have the right not to be transferred to another facility or organization, except in an emergency or as authorized by law, without your consent to the transfer, including a complete explanation and alternatives to a transfer. (The other facility and you must accept the transfer.)
- You have the right to request an itemized and detailed explanation of charges for services rendered, and to be provided with financial counseling free of charge, as appropriate.
- Northside Hospital and its affiliated practices strive to provide satisfactory care, however if you have a concern that you feel was not satisfactorily addressed, you have the right to contact a Patient Relations representative. You also have the right to file a concern with the Georgia Department of Community Health. You may reach them at 404-656-4507 or by mail at 2 Peachtree Street, NE, 33rd Floor, Atlanta, GA 30303. Patient safety concerns can be reported to The Joint Commission:
  - At www.jointcommission.org, using the "Report a Patient Safety Event" link in the "Action Center" on the home page of the website
  - By fax to 630-792-5636
  - By mail to Office of Quality and Patient Safety, The Joint Commission, One Renaissance Boulevard, Oakbrook Terrace, IL 60181
- If you are admitted to Northside Hospital, you will be notified of additional rights you may have as a hospital patient.

YOUR RESPONSIBILITIES

In order to create a partnership that will improve your care, we ask that you give careful consideration to your responsibilities to:

- Provide, to the best of your knowledge, accurate and complete information about your health history, current condition and current medication and adverse reactions.
- Ask questions if you do not understand any aspect of the care, treatment, or services provided for you.
- Cooperate with your doctor, nurse, and other caregivers.
- Follow the recommended treatment plan.
- Report changes in your condition or anything you think might be a risk to you.
- Ask the doctor or nurse what to expect regarding pain and pain management.
- Take responsibility for the outcome if you decline or refuse the recommended treatment.
- Communicate your wishes regarding end of life decisions, including advance directives, with your family, physician, personal attorney and spiritual advisor.
- Discuss your wishes regarding organ/tissue/eye donation with your family, physician, personal attorney, and spiritual advisor.
- Show respect and consideration of others.
- Respect the privacy rights of others. Photographs, films, videos, and voice recordings of other patients or staff are not permitted.
- Follow the practice's policies and regulations.
- Fulfill the financial obligations of receiving care, including accepting financial responsibility for any consultations with physicians or specialists, including pain specialists.
- Request interpretation services when necessary.
- Know that "more" is not always better. It is a good idea to find out why a test or treatment is needed and how it can help you.
- If you have a test, don't assume no news is good news. Always ask for the results of all tests.