



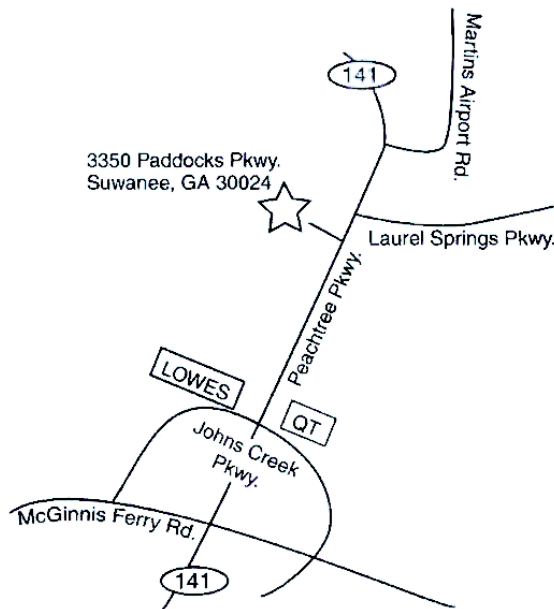
## Welcome to John's Creek Specialist Center

We at John's Creek Specialist Center are committed to excellence in healthcare. Our well-trained team is focused on providing a high standard of care in a warm, efficient office environment. We realize that you have a choice regarding your medical care. We appreciate and value your business, and we will strive to do everything we can to provide you with the personalized service you deserve.

### Directions

John's Creek Specialist Center is located at 3350 Paddocks Parkway in Suwanee. If this map does not help you with your route to our office, and if you have Internet access, just go to <http://maps.google.com>, and you can create custom turn-by-turn directions from your location.

If you do not have access to the Internet, or if the resulting directions are not helpful to you, just call our office at 678-679-6210, and we'll be glad to help you with directions.



### New patient forms

To make your first visit as smooth as possible, and to allow us to better understand your medical needs, we would appreciate your filling out the attached forms before your initial appointment.

You can accomplish this electronically with Adobe Acrobat Reader.

Here's how...

- Just click in each answer area and type in your response.
- When you are finished, choose "Save As..." from the "File" menu, and name the file with your last name.
- Attach the completed file to an e-mail addressed to [ddavis@johnscreeks.com](mailto:ddavis@johnscreeks.com).

Alternatively, you can print the forms, fill them out by hand, and bring them with you at the time of your visit.

Thank you for your help!



Tel 678-679-6210  
3350 Paddocks Parkway

Fax 678-679-6220  
Suwanee, GA 30024

**Patient Registration**

**Personal information**

Last \_\_\_\_\_

First \_\_\_\_\_ Middle \_\_\_\_\_

Street (mailing) address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home phone \_\_\_\_\_ Work phone \_\_\_\_\_

Mobile phone \_\_\_\_\_ E-mail \_\_\_\_\_

Primary care provider \_\_\_\_\_ Referring provider \_\_\_\_\_

Date of birth \_\_\_\_\_ SS# (insurance billing purposes only) \_\_\_\_\_

Marital status    single    married    divorced

**Insurance information**

Primary insurance \_\_\_\_\_ Phone \_\_\_\_\_

Subscriber name \_\_\_\_\_ Subscriber ID group number \_\_\_\_\_

Billing address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Employer information**

Employer name \_\_\_\_\_ Phone \_\_\_\_\_

Street address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Emergency and pharmacy contact information**

Emergency contact name \_\_\_\_\_ Phone \_\_\_\_\_

Pharmacy name \_\_\_\_\_ Phone \_\_\_\_\_

**Johns Creek Specialist Center policy**

Johns Creek Specialist Center requires payment at time of service for the total amount not covered by your insurance. Our office will be happy to file your charges to your insurance company. If you are a participating member of a managed care plan, we will expect your co-payment, and any other fees that are not covered, at the time of your visit. If your insurance company is one we do not participate with, or if you are a self-pay patient, you will be asked to pay in full for your visit.

We participate in many plans and attempt to keep our staff fully up-to-date with changes and updates to laboratory fees, referral requirements, pre-certifications, etc. We feel that it is also the patient's responsibility to be aware of how your insurance plan and your benefits package work. Any patient who fails to notify our office of any changes in their insurance that in turn deems your services as non-covered will be billed directly.

You will be required to sign a patient information sheet on every visit to verify your information is correct and current.

Thank you for choosing Johns Creek Specialist Center. We appreciate your business and will do everything we can to provide you with the high level of medical care you deserve.

*By signing this form, I give Johns Creek Specialist Center. and its providers to treat the patient listed above. In addition, I give authorization to file my insurance claim and assign benefits to Johns Creek Specialist Center. By signing this, I also agree to the above information and conditions.*

Signature of patient or guardian

Date of signature

Print name





**Please mark any of the following symptoms that you are experiencing.**

**General**

- unexplained rapid weight gain       fever       unexplained rapid weight loss
- 
- extreme tiredness
- 

**Endocrine**

- excessive sweating/night sweats       low blood sugar       calcium problems
- 
- potassium problems       heat/cold intolerance       adrenal problems
- 
- thyroid problems       pituitary problems
- 

**Eyes**

- eye laser treatments       glaucoma       poor vision/blindness
- 
- macular degeneration       tunnel vision (poor peripheral vision)       double vision
- 
- color blindness       retinal detachment
- 

**ENT**

- loss of hearing/deafness       dentures/bridges       mouth dryness
- 
- difficulty swallowing       changes in voice, hoarseness       pain in front of the neck
- 
- enlarged thyroid or neck lumps       impaired smell or taste
- 

**Heart/lungs**

- use oxygen       sleep apnea, use CPCP/BiPAP       shortness of breath on exertion
- 
- pacemaker or internal defibrillator       blood in sputum       short of breath at night/rest
- 
- chest/arm/jaw discomfort on exertion       asthma or COPD       slow, fast or irregular heart beat
- 
- long term cough       ankle/leg swelling with water       calf pain while walking
- 

**Breast**

- nipple discharge       breast lump/mass       breast pain/tenderness or swelling
- 

**Gastrointestinal**

- nausea       vomiting       early satiety
- 
- eating disorder       diarrhea       constipation
- 
- irritable bowel       crohn's disease or colitis       frequent heartburn, indigestion
- 
- abdominal pain       bloody or black, tarry stools       food intolerances
- 

**Blood**

- history of blood clots       bleeding problems       easy bruising
- 
- anemia       radiation treatments to head, neck or whole body
- 

**Urological**

- frequent bladder or vaginal infections       kidney problems       kidney stones
- 
- frequent urination
- 

**Men only**

- pain or lump in testicles       STD/discharge       difficulty achieving/maintaining erections
- 
- change in desire to have sexual intimacy (libido)
-

**Women only**

date of last period                       irregular periods                       spotting between periods

pregnant now                      Number of pregnancies                      Number of live births

contraception use (birth pill, iuds, condoms, vasectomy)

**Muscle/bones**

muscle aches                       muscle weakness                       gout

arthritis                       fractures                       amputations

**Skin**

foot/leg ulcers                       skin rash                       darkening or lightening of the skin

dry skin                       hair loss                       brittle nails

**Neuro/psych**

frequent severe headaches                       dizziness                       previous head injury

unsteady gait                       seizures                       loss of consciousness

paralysis                       tremor                       burning, shooting pain in hands/feet

decreased sensation/feet                       memory loss                       depression/anxiety/fears

Anything else you would like us to know about you?

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3350 Paddocks Parkway

Fax 678-679-6220  
Suwanee, GA 30024

## Authorization and Consent for Release of Medical Records to Include Previous Medical Office

I, the signed patient, or legal guardian of patient, hereby authorize...

Name of physician, medical practice, or treating hospital \_\_\_\_\_

Address of facility \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_

Zip \_\_\_\_\_

Fax — very important \_\_\_\_\_

Telephone \_\_\_\_\_

...to release the medical information listed below from the records of this patient:

Name of patient \_\_\_\_\_

Released records to cover the following dates of hospitalization and/or outpatient services:

Dates of records requested \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I understand that this authorization includes release of all medical records, including those covering HIV, psychiatric, mental illness, drug/alcohol abuse, venereal disease and/or any other statutorily protected diseases. This authorization and consent will expire ninety (90) days following the date signed.

I understand that I may revoke this authorization and consent at any time with the understanding that action has previously been taken in reliance hereof.

Signature of patient/guardian \_\_\_\_\_

Date \_\_\_\_\_

Print name \_\_\_\_\_

Date of birth \_\_\_\_\_

Social Security number \_\_\_\_\_



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## Request for Medical Forms Completion

Johns Creek Specialist Center strives to provide the best medical care we possibly can.

We understand that you may occasionally need some forms filled out by one of our providers (e.g., insurance forms, disability forms, handicap permit forms, immunization forms, etc.).

These forms require a lot of time on the part of our providers. We are happy to assist in any way we can, but please know we have no way of charging your insurance for the time forms take to research and complete. Therefore, we find it necessary to charge you a minimal fee for this service.

*You can accept or decline this service by checking your choice below:*

### Please check one

- I accept the terms above and also accept the \$25.00 per request for any forms completed by one of Johns Creek Specialist Center's providers. I accept my account being billed this fee upon my request. I understand if payment is not received within 60 days of invoicing, my account will be sent to collections for this fee only.
- I do not wish to accept the terms above, and I realize if I utilize this service at anytime in the future, the completed forms will not be provided to me until payment is arranged

Signature of patient/guardian \_\_\_\_\_

Date \_\_\_\_\_

Print name \_\_\_\_\_



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## Financial Patient Policies

### Billing policy

Our office will be happy to file your charges for services rendered to your insurance company. If you are a participating member of a managed care plan, we will expect you to pay your co-payment and/or any other fees that are non-covered at the time of your visit. If your insurance is one that we do not participate with or you are a self-pay patient, you will be asked to pay in full for your visit upon check out.

We participate on many plans and it is difficult to always be 100% accurate with the changes that insurance companies make in regard to laboratory work, referral requirements, pre-certifications, etc. We attempt to keep our office staff fully educated to most recent changes and updates. We feel strongly that it is also the patient's responsibility to be aware of how their insurance plans works and your benefit package. Any patient who is seen and fails to notify our office of any changes in their insurance that in turn deems your services as non-covered will be billed directly for these charges.

### Check policy and balances

We are happy to accept your personal check for payment toward your account balance. However, if funds are not available in your account and your check is returned to us as an NSF (or any other reason), you will be your bill will be assessed a \$25.00 service fee plus the cost of the original check. If you present two checks that are insufficient, then we will no longer accept payment by check on your account. All funds must then be paid by cash or credit card. All patients will be mailed a statement on any remaining balance on their account. The patient will be given 60 days to pay the balance in full or make other arrangements with this office. After 60 days this debt will be sent to collections.

### Administration fee

This office will charge an administration fee for any forms you may need during the calendar year. The form administration fee is \$25.00. This is optional, but you will be charged \$25.00 per request if at anytime during the year you need any administrative forms.

### No-show policy

Any time that you miss an appointment without giving any notification, you will be assessed a \$35.00 no-show fee for office visits and \$50.00 for physical appointments. This will be your responsibility to pay and this fee must be paid prior to your next visit.

### Patient acknowledgement

I have read and hereby understand the above policies.

Patient signature \_\_\_\_\_

Date \_\_\_\_\_

Print patient name \_\_\_\_\_

*If you would like a copy of this signed policy, please ask our office manager.  
Thank you for your business and your understanding of this policy.*



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## Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Johns Creek Specialist Center to use and disclose my protected health information to carry out treatment, payment and healthcare operations.

I have the right to review the notices of privacy practices prior to signing this consent. Johns Creek Specialist Center reserves the right to revise the Notice of Privacy Practices at any time. A revised Notice of Privacy Practice may be obtained by forwarding a written request to Johns Creek Specialist Center at the above address.

With this consent, Johns Creek Specialist Center may call my home, or other alternative locations, and leave a message on a voice mail or with a person in reference to any items that assist the practice in carrying out treatment, payment, and healthcare operations, such as appointment reminder phone calls or cards and patient statements, as long as they are marked as personal and confidential.

I have the right to request Johns Creek Specialist Center restrict how it uses or discloses my protected health information to carry out my treatment, payment, or healthcare operations. However, Johns Creek Specialist Center is not required to agree to accept my request. If Johns Creek Specialist Center agrees to accept my request, Johns Creek Specialist Center will be bound by the request. By signing this form, I am consenting to Johns Creek Specialist Center's use and disclosure of my Protected Health Information.

I understand that I may revoke this consent in writing to the extent that the practice has already made disclosure and reliance upon my prior consent. I further understand that if I do not consent to the Protected Health Information, or later revoke this consent, Johns Creek Specialist Center may decline to provide treatment.

Print patient name \_\_\_\_\_

Date of birth \_\_\_\_\_

Patient signature \_\_\_\_\_

Date \_\_\_\_\_

## HIPAA Notice of Privacy Practices

*Northside Hospital, Inc. and Affiliates*

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

### Who Will Follow This Notice

This notice describes Northside Hospital's practices and that of:

- Any health care professional authorized to enter information into your hospital chart, including members of the Northside Hospital Medical Staff
- All departments and units of the hospital, including outpatient facilities
- Any member of a volunteer group we allow to help you while you are in the hospital
- All employees, staff and other hospital personnel. Northside Hospital and its Medical Staff members operate as an "organized health care arrangement" and are presenting this document as 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, Medical Staff members are not employees or agents of the Hospital and remain independent contractors.

All these entities, sites and locations follow the terms of this notice. In addition, these entities, sites and locations may share medical information with each other for treatment, payment or health care operations purposes described in this notice.

### Our Pledge Regarding Medical Information

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive at the hospital. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by the hospital, whether made by hospital personnel or your personal doctor. Your personal doctor may have different policies or notices regarding the doctor's use and disclosure of your medical information created in the doctor's office or clinic.

This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

We are required by law to:

- Make sure that medical information that identifies you is kept private
- Give you this notice of our legal duties and privacy practices with respect to medical information about you; and follow the terms of the notice that is currently in effect

### How We May Use and Disclose Medical Information About You

The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures, we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

**For Treatment:** We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other hospital personnel who are involved in taking care of you at the hospital. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. In addition, the doctor may need to tell the dietitian if you have diabetes so that we can arrange for appropriate meals. Different departments of the hospital also may share medical information about you in order to coordinate the different things you need, such as prescriptions, lab work and x-rays. We also may disclose medical information about you to people outside the hospital who may be involved in your medical care after you leave the hospital, such as family members, clergy or others we use to provide services that are part of your care.

**For Payment:** We may use and disclose medical information about your treatment and services to bill and collect from you, your insurance company or a third party payer. For example, we may need to give your health plan information about your surgery so that they will pay us or reimburse you for the surgery. We may also tell your health plan about a treatment you are going to receive to determine whether your plan will cover it.

**For Health Care Operations:** We may use and disclose medical information about you for hospital operations. These uses and disclosures are necessary to run the hospital and make sure that all of our patients receive quality care. (For example, in the course of quality assurance and utilization review activities, we may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you. Some of these reviews may be conducted by independent physicians who are members of the medical staff, but not Northside Hospital employees). We may also combine medical information about many hospital patients to decide what additional services the hospital should offer and what services are not needed. We may also disclose information to doctors, nurses, technicians, medical students, and other hospital personnel for review and learning purposes. We may also combine the medical information we have with medical information from other hospitals to see where we can make improvements. We may remove information that identifies you from this set of medical information to protect your privacy.

**Appointment Reminders:** We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or medical care at the hospital.

**Treatment Alternatives:** We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

**Health-Related Benefits and Services:** We may use and disclose medical information to tell you about health-related benefits or services that may be of interest to you.

**Fundraising Activities:** We may use medical information about you to contact you in an effort to raise money for the hospital and its operations. We may disclose medical information to a foundation related to the hospital so that the foundation may contact you in raising money for the hospital. We only would release contact information, such as your name, address and telephone number and the dates you received treatment or services at the hospital. If you do not want the hospital to contact you for fundraising efforts, you must notify the Director of Northside Hospital Foundation, 1000 Johnson Ferry Road, Atlanta, GA 30342 in writing.

**Hospital Directory:** We may include certain limited information about you in the hospital directory while you are a patient at the hospital. This information may include your name, location in the hospital, your general condition (e.g., fair, stable, etc.) and your religious affiliation. Unless there is a specific written request from you to the contrary, this directory information, except for your religious affiliation, may also be released to people who ask for you by name. Your religious affiliation may be given to a member of the clergy, such as a priest or rabbi, even if they don't ask for you by name. This information is released so your family, friends and clergy can visit you in the hospital and generally know how you are doing. If you do not want your information to be listed in the hospital directory, please ask to be listed as a "No-Information" patient.

**Individuals Involved in Your Care or Payment for Your Care:** We may release medical information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

**Research:** Under certain circumstances, we may use and disclose medical information about you for research purposes. We generally will obtain your written authorization to use your medical information for research purposes. There may be limited circumstances when access to your information for research purposes may be allowed without your specific consent. These will be limited to cases when use or disclosure was approved by an Institutional Review Board or Privacy Board.

**Business Associates:** There are some services provided in the Hospital through contracts with business associates. One example is the copy service we use when making copies of your health record. When these services are contracted, we may disclose your healthcare information to our business associate so that they can perform the job we have asked them to do. To protect your health information, however, we require the business associate to appropriately safeguard your information.

**As Required By Law:** We will disclose medical information about you when required to do so by federal, state or local law.

**To Avert a Serious Threat to Health or Safety:** We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

## Special Situations

**Organ and Tissue Donation:** If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

**Military and Veterans:** If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.

**Workers' Compensation:** We may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness. Your written

authorization to this release is required, however, if you do not consent to release of information, your workers' compensation benefits may be denied and you will be responsible for the costs of your medical care.

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

- To prevent or control disease, injury or disability
- To report births and deaths
- To report the abuse or neglect of children, elders and dependent adults
- To report reactions to medications or problems with products
- To notify people of recalls of products they may be using
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition

**Health Oversight Activities:** We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

**Lawsuits and Disputes:** If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request (which may include written notice to you) or to obtain an order protecting the information requested.

- Law Enforcement: We may release medical information if asked to do so by a law enforcement official.
- In response to a court order, subpoena, warrant, summons or similar process
- To identify or locate a suspect, fugitive, material witness, or missing person
- About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement
- About a death we believe may be the result of criminal conduct
- About criminal conduct at the hospital
- In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

**Coroners, Medical Examiners and Funeral Directors:** We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients of the hospital to funeral directors as necessary to carry out their duties.

**National Security and Intelligence Activities:** We may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

**Protective Services for the President and Others:** We may disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.

**Inmates:** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

## Your Rights Regarding Medical Information About You

You have the following rights regarding medical information we maintain about you:

**Right to Inspect and Copy:** You have the right to inspect and copy medical information that may be used to make decisions about your care. If you are a current inpatient, you should notify your primary nurse and complete the required form. If you are an outpatient or discharged patient, you should contact the Director of Health Information Services in writing, at the appropriate service location (as listed at the end of this Notice) to obtain and complete the required form. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care

professional chosen by the hospital will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

**Right to Amend:** If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the hospital. If you are a current inpatient, you should notify your primary nurse and complete the required form. If you are an outpatient or discharged patient, you should contact the Director of Health Information Services in writing, at the appropriate service location (as listed at the end of this Notice) to obtain and complete the required form. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment
- Is not part of the medical information kept by or for the hospital
- Is not part of the information which you would be permitted to inspect and copy, or
- Is accurate and complete

**Right to an Accounting of Disclosures:** You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you other than our own uses for treatment, payment and health care operations, as those functions are described above. To request this list or accounting of disclosures, you should contact the Director of Health Information Services in writing, at the appropriate service location (as listed at the end of this Notice) to obtain and complete the required form. 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 want the list (for example, on paper, electronically). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

**Right to Request Restrictions:** You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care. Because any restrictions of your information may hinder the quality of care provided by our facility, according to the law, we reserve the right to deny your request. In addition, because of the many health care providers participating in the organized health care arrangement (Northside Hospital and its Medical Staff members), we generally cannot agree to special requests. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

To request restrictions, you should contact the Director of Health Information Services in writing, at the appropriate service location (as listed at the end of this Notice) to obtain and complete the required form. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse. To be binding, any agreement to comply with special restrictions must be in writing signed by the Director of Health Information Services.

**Right to Request Confidential Communications:** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to Northside Hospital, Attn: Patient Access Department Manager, 1000 Johnson Ferry Road, Atlanta, GA 30342. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

**Right to a Paper Copy of This Notice:** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

You may obtain a copy of this notice at our website, [www.northside.com](http://www.northside.com).

To obtain a paper copy of this notice, you may contact Northside Hospital, Attn: Patient Access Department Manager, 1000 Johnson Ferry Road, Atlanta, GA 30342.

## Changes to This Notice

We reserve the right to change this notice and the revised or changed notice will be effective for medical information we already have about you as well as any information we receive in the future. The current notice will be posted in the hospital and will include the effective date. In addition, each time you register at or are admitted to the hospital for treatment or health care services as an inpatient or outpatient, we will offer you a copy of the current notice in effect.

## Complaints

If you believe your privacy rights have been violated, you may file a complaint with the hospital or with the Secretary of the Department of Health and Human Services. To file a complaint with the hospital,

contact the Privacy Officer at your location of service (as listed below). All complaints must be submitted in writing.

You will not be penalized for filing a complaint.

**Other Uses of Medical Information**

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

Privacy Officer and Director of Health Information Services Contact Information:  
Northside Hospital – Main Campus (Atlanta), Alpharetta, Johns Creek, Meridian Mark,  
and All Other Metro Atlanta facility locations:  
1000 Johnson Ferry Road, Atlanta, GA 30342  
Privacy Officer Contact Phone: 404-845-5534

Northside Hospital – Cherokee Towne Lake and All Other Cherokee Area facility locations:  
201 Hospital Road, Canton, GA 30114  
Privacy Officer Contact Phone: 770-720-5345

Northside Hospital – Forsyth and All Other Forsyth Area facility locations:  
1200 Northside Forsyth Drive, Cumming, GA 30041  
Privacy Officer Contact Phone: 770-844-3272

**I, the undersigned patient, or legal guardian of patient, hereby acknowledge that I have read and understand this document.**

Signature of patient/guardian \_\_\_\_\_

Date \_\_\_\_\_

Print name \_\_\_\_\_

*Document effective date, April 14, 2003*