WILLIS-KNIGHTON HEALTH SYSTEM

IDENTIFICATION DATA (Please print the following information)

Date _____ Age _____

Patient Name _____ Male___ Female____ Date of Birth _________

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

_____ Residence Phone ( )_____

_____ Business Phone ( )_____

FAMILY HISTORY − List Immediate family members who have died (Father, Mother, etc.):

_____

_____

_____

Circle Illnesses immediate family members have had:

Tuberculosis	Heart Disease	Hay Fever	Glaucoma
Diabetes	High Blood Pressure	Asthma	
Cancer	Allergies	Sickle Cell Anemia	

PATIENT HISTORY Please check if your medical history includes:

Date of last dental exam: _____

REVIEWER NOTES

EYE, EAR, NOSE
1. Hay Fever ____
2. Ear Infection ____
3. Hearing Loss ____
4. Eye Problems ____

GASTROINTESTINAL
5. Stomach Pain ____
6. Ulcers ____
7. Change In bowel Habits ____
8. Rectal Bleeding ____
9. Jaundice (Hepatitis) ____

CARDIO−RESPIRATORY
10. Trouble Breathing ____
11. Cough (If chronic) ____
12. Asthma ____
13. High Blood Pressure ____
14. Rheumatic Fever ____
15. Heart Disease ____
16. Activity Limitation ____
17. EKG−Last Date _____
18. Chest X−Ray − Date _____

GENITOURINARY
19. Difficulty starting stream ____
20. Night time urination ____
21. Kidney Disease ____
22. Urinary Infection ____

NEURO−MUSCULAR
23. Weakness ____
24. Numbness/Tingling ____
25. Muscle Pain ____
26. Seizures/Epilepsy ____
27. Paralysis ____
28. Migraine/Headaches ____

SKELETAL
29. Joint Pain or Swelling ____
30. Back Problems ____
31. Arthritis ____

ENDOCRINE
32. Diabetes ____
33. Thyroid Problems ____
34. Recent Weight Gain/Loss (10 pounds) ____

HEMATOLOGIC
35. Sickle Cell Disease ____
36. Anemia ____
37. Bleeding Tendencies ____
38. Thrombophlebitis/blood clots ____

OTHER (Additional space on back)
39. Cancer ____
40. Mental/Emotional Problems ____
41. Venereal Disease History ____
42. Tetanus Immunization
Last Date: _____

FOR WOMEN ONLY
43. Irregularity of Periods_____ 44. Abnormal Flow_____ 45. PID/Pelvic Pain_____ 46. Breast Disease____
47. Last Menstrual Period, Date:_____ 48. Last Pelvic/Pap Smear Date:_____
49. Birth Control? If so, what type:_____ 50. Number of Pregnancies:_____ Number of Births:_____

WILLIS-KNIGHTON HEALTH SYSTEM

IDENTIFICATION DATA continued

Patient Name _____ Date of Birth _________

Patient History. Cont'd.

PLEASE LIST ALL SURGERIES, HOSPITALIZATIONS, AND/OR SERIOUS INJURIES:

_____

_____

_____

PLEASE INCLUDE ALL CURRENT PRESCRIPTIONS, OVER THE COUNTER MEDS, HERBALS, PATCHES, INHALER, EYE DROPS & SUPPLEMENTS:

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PLEASE NAME ANY DRUG ALLERGIES/ADVERSE REACTIONS:

_____	_____	_____
_____	_____	_____
_____	_____	_____

CURRENT LIFE STYLE: Name your current occupation _____

	NO	YES
Do you use alcohol more than four times per week?	_____	_____
Do you smoke?	_____	_____
Do you ever use drugs recreationally?	_____	_____
Do you feel safe in your environment?	_____	_____

Indicate any abnormality	YES	NO	Description
A) Eyes	_____	_____	_____
B) Ears, Nose, Throat	_____	_____	_____
C) Skin	_____	_____	_____
D) Nervous System	_____	_____	_____
E) Chest	_____	_____	_____
F) Heart	_____	_____	_____
G) Abdomen	_____	_____	_____
H) Genito−Urinary System	_____	_____	_____
I) Pelvic	_____	_____	_____
J) Extremities	_____	_____	_____
K) Back	_____	_____	_____
L) Pain − Location	_____	_____	Pain Scale 0 1 2 3 4 5 6 7 8 9 10

Reviewed with patient by _____

Provider Signature Date/Time

WILLIS-KNIGHTON HEALTH SYSTEM

Clinic Patient Information Record

Patient Name/Last:	First:	Middle:	SSN:	
Residence Address:	City:	State:	Zip:	
Mailing Address: (Check here if same as above)☐				
Home Telephone Number:	Cell Phone Number:	Email Address:		
Date of Birth/Month: Day: Year:	☐ Male ☐ Female	Race:	Ethnicity:	☐ Hispanic or Latino ☐ Not Hispanic or Latino
Employer's Name:	Work Telephone Number:	Ext:		
Preferred Language: ☐English ☐ Spanish ☐ Other	Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced			
Communication Needs				
Responsible Party: (check here if same as above)☐				
Name/Last:	First:	Middle:	Responsible party's SSN:	Date of birth:
Mailing Address:	City:	State:	Zip:	
Home Telephone Number:	Relationship to Patient:			
Employer's Name:	Work Telephone Number:	Ext:		
Responsible Party's Spouse's Name (if applicable):	SSN:			
In Case of an Emergency, who may we notify (other than someone living with you)	Relationship to Patient:			
Name:	Date of Birth:	Telephone Number:		
Address:	City:	State:	Zip:	
Who referred you to our office?	Telephone Number:			
Insurance Coverage	Is your Illness/injury due to an Auto/Work Accident? Yes ☐ No ☐			
Insurance #1 Name of Insurance Company:				
Policy Number	Group Number:			
Employer:	Guarantor:			
Insurance # 2 Name of Insurance Company:				
Policy Number	Group Number:			
Employer:	Guarantor:			
Insurance # 3 Name of Insurance Company:				
Policy Number	Group Number:			
Employer:	Guarantor:			
Preferred Pharmacies:				

FS0005

WILLIS-KNIGHTON HEALTH SYSTEM

Payment Policy
Willis−Knighton
Network Physicians

Patient Name: _____ Date of Birth: _____

Payment arrangements are understood and agreed upon by the patient and provider prior to services being rendered.

Willis−Knighton Health System participates with and accepts most insurance plans. **Patients are required to furnish proof of insurance at the time of service.** As a courtesy to our patients, we will be happy to file the insurance claim(s) for services rendered by any of the 80+ providers participating within the Willis−Knighton Physician Network.

Monthly statements are generated and mailed to patients/guarantors to make them aware of any outstanding balance after insurance coverage has been exhausted. **Any outstanding balance is considered the guarantor's responsibility regardless of insurance coverage.**

An account will be deemed delinquent after 90 days from the date of service or from the date services were denied or paid by the insurance carrier.

Annual deductible amounts will be the obligation of the guarantor. If the patient has met his/her deductible for the current year and can verify this with an Explanation of Benefits from his/her insurance carrier, the remainder of the patient responsibility (such as 20% for most insurance plans) will be due at the time of visit.

Co−payments for HMO's, PPO's, and other managed care plans must be paid at the time of service. Balance billing patients for their co−pays is a violation of many managed care contracts and will not be allowed. **Co−payments will be collected at check−in before the physician sees the patient.** If the patient does not have the co−pay at the time of visit, the patient may reschedule the appointment in order to meet the co−pay requirement.

Should the patient or responsible party express an inability to pay, alternate payment plans and assistance are available upon request. The physician and/or clinic manager must approve monthly payment plans and discounts. Patients must agree in writing to the payment plan prior to seeing the physician.

My signature below verifies that I have read and understand the payment policy outlined above.

_____ _____
Patient (if over 18 years of age) Date

_____ _____
Guarantor (if patient is under 18 years of age) Date

WILLIS-KNIGHTON PHYSICIAN NETWORK

Notice of Privacy Practices

This notice describes how Willis−Knighton Health System may use and disclose your medical information, and how you may access this information. Please review it carefully.

If you have any questions about this Notice, please contact our Privacy Officer, Jaf Fielder , at 1 (888) 884−2499, or by email at jfielder@wkhs.com.

We are required by law to maintain the privacy of your Protected Health Information, to notify you of our legal duties and privacy practices with respect to your health information, and to notify affected individuals following a breach of unsecured health information. This Notice summarizes our duties and your rights concerning your information. Our duties and your rights are set forth more fully in 45 CFR Part 164. We are required to abide by the terms of our Notice that is currently in effect.

This Notice of Privacy Practices describes Willis−Knighton's practices, and that of any of our affiliates. All employees, staff, and other personnel will 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 operation purposes as described in this Notice.

Changes to this Notice:

We reserve the right to change the terms of our Notice at any time. Any revisions of the Notice will be effective for all Protected Health Information that we maintain at that time. To receive a copy of the revised Notice, you may contact our Privacy Officer and request that a revised copy be sent to you in the mail or it is also available online at www.wkhs.com. Additionally, you may also obtain a copy in the Admissions Office at the time of your next appointment.

Willis−Knighton's Commitment to Protecting Medical Information:

We understand and appreciate the personal nature of any information related to you and your health. Willis−Knighton is committed to protecting your medical information, and are required by law to:

- Ensure the privacy of your identifiable medical information;
- Provide you with this notice of our legal duties and privacy practices with respect to your medical information; and
- Follow the terms of the most current Notice.

This Notice of Privacy Practices describes how we may use and disclose your Protected Health Information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your Protected Health Information.

"Protected Health Information" refers to information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information Based Upon Your Written Consent

You will be asked by Willis−Knighton to sign a consent form. Once you have consented to use and disclosure of your Protected Health Information for treatment, payment and health care operations by signing the consent form, Willis−Knighton will use or disclose your Protected Health Information as described in this Section.

Each category of uses and disclosures will be explained but not every use or disclosure in each category will be listed. However, every permissible use or disclosure will fall under one of the following categories.

Treatment: We will use and disclose your Protected Health Information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your Protected Health Information. We may disclose your Protected Health Information, as necessary, to doctors, nurses, counselors, physician assistants, nurse practitioners, or any other personnel involved in your care. For example, your Protected Health Information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. In addition, we may disclose your Protected Health Information to another physician or health care provider who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

Payment: Your Protected Health Information will be used and disclosed, as needed, to obtain payment for your health care services. This may include uses and disclosures by and to the Health Information Management Department and our Business Office. Other uses and disclosures may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you, such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant Protected Health Information be disclosed to the health plan to obtain approval for the hospital admission.

Health care Operations: We may use or disclose, as needed, your Protected Health Information in order to support Willis−Knighton's hospital operations and business activities. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing and fundraising activities, conducting or arranging for other business activities and compliance with state law.

For example, we may disclose your Protected Health Information to medical school students that see patients in our hospitals. In addition, we may use a sign−in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your Protected Health Information, as necessary, to contact you to remind you of your appointment. We will share your Protected Health Information with third party "business associates" that perform various activities (e.g., billing, transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your Protected Health Information, we will obtain a written contract that contains terms that will protect the privacy of your Protected Health Information.

We may use or disclose your Protected Health Information, as necessary, to provide you with information about treatment alternatives or other health−related benefits and services that may be of interest to you. We may also use and disclose your Protected Health Information for other marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer. We may also send you information about products or services that we believe may be beneficial to you.

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization

Other uses and disclosures not described in this Notice will be made only with your written authorization, including most uses or disclosures of psychotherapy notes, for most marketing purposes or if we seek to sell your information. You may revoke your authorization by submitting a written notice to the Privacy Officer identified above. The revocation will not be effective to the extent Willis−Knighton has already taken action in reliance on the authorization.

Other Permitted and Required Uses and Disclosures That May Be Made With Your Consent, Authorization or Opportunity to Object

We may use and disclose your Protected Health Information in the following instances. You will be granted the opportunity to agree or object to the use or disclosure of all or part of your Protected Health Information. If you are not present or able to agree or object to the use or disclosure of the Protected Health Information, then in our best professional judgment, Willis−Knighton may determine whether the disclosure is in your best interest. In this case, only the minimum necessary Protected Health Information relevant to your health care will be disclosed.

Others Involved in Your Healthcare: Unless you instruct us otherwise, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your Protected Health Information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose Protected Health Information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition, or death. Finally, we may use or disclose your Protected Health Information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Emergencies: We may use or disclose your Protected Health Information in an emergency treatment situation. If this happens, Willis−Knighton staff shall attempt to obtain your consent as soon as reasonably practicable after the delivery of treatment. If your physician or any Willis−Knighton staff member is required by law to treat you and has attempted to obtain your consent but is unable to obtain your consent, he or she may still use or disclose your Protected Health Information to treat you.

Communication Barriers: We may use and disclose your Protected Health Information if we attempt to obtain consent from you but are unable to do so due to substantial communication barriers and we determine, using professional judgment, that you intend to consent to use or disclosure under the circumstances.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Consent, Authorization or Opportunity to Object

We may use or disclose your Protected Health Information in the following situations without your consent or authorization. These situations include, but are not limited to, the following:

Required By Law: We may use or disclose your Protected Health Information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the minimum necessary. You will be notified, as required by law, of any such uses or disclosures. We may use or disclose your information to state agencies for registry purposes as appropriate and required under State of Louisiana law, for example, vital statistics, tumor, burn or trauma registries.

Public Health: We may disclose the minimum necessary amount of your Protected Health Information for public health activities to a public health authority that is permitted by law to collect or receive the information. These uses and disclosures may include, but are not limited to, the following:

- To prevent or control disease, injury, or disability;
- To report child abuse or neglect by making a telephone report to the appropriate authorities, and to follow this report with a written confirmation;
- To report reaction to medication or problems with products as required by the Food and Drug Administration;
- 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; or
- To notify the appropriate government authority if we believe a client has been the victim of domestic violence. We will only make this disclosure if you agree, and when consistent with the requirements or authorizations of applicable Louisiana and federal law.

Health Oversight: We may disclose Protected Health Information to a health oversight agency for activities authorized by law, such as audits, investigations, inspections, and licensure. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Legal Proceedings: We may disclose Protected Health Information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may also disclose Protected Health Information, so long as applicable legal requirements are met, for law enforcement purposes. We may release the minimum necessary information if asked to do so by a law enforcement official:

- In response to a proper court order or similar process;
- In response to a subpoena for a staff member of Willis−Knighton;
- About criminal conduct involving our facility;
- Suspicion that death has occurred as a result of criminal conduct;
- In the event that a crime occurs on the premises of the practice; or
- Medical emergency (not on Willis−Knighton's premises) and it is likely that a crime has occurred.

Coroners, Funeral Directors, and Organ Donation: We may disclose Protected Health Information to a coroner or medical examiner for identification purposes, cause of death determination, or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose Protected Health Information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected Health Information may be used and disclosed for organ, eye, or tissue donation purposes.

Research: We may disclose your Protected Health Information to researchers when an institutional review board has reviewed the research proposal and established protocols to ensure the privacy of your Protected Health Information. In most cases, the medical information will be de−identified for privacy purposes.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your Protected Health Information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose Protected Health Information if it is necessary for law enforcement authorities to identify or apprehend an individual. Any such disclosure would be limited to the minimum necessary, and would be made to someone involved in the prevention of the threat.

Military Activity: When the appropriate conditions apply, we may use or disclose Protected Health Information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services.

Workers' Compensation: We may disclose your Protected Health Information for workers' compensation and other similar legally established programs, in accordance with state and federal law regarding such disclosures.

National Security: We may disclose your Protected Health Information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Required Uses and Disclosures: By law, we must make minimum necessary disclosures when required to do so by state, federal, or local law.

2. Your Rights Regarding your Protected Health Information

Following is a statement of your rights with respect to your Protected Health Information and a brief description of how you may exercise these rights.

Right to Inspect and Copy: This means you may inspect and obtain a copy of Protected Health Information about you that is contained in a designated record set for as long as we maintain the Protected Health Information. A "designated record set" contains medical and billing records and any other records that your physician and the practice uses for making decisions about you.

Under federal law, however, this generally does not apply to the following: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and Protected Health Information that is subject to law that prohibits access to Protected Health Information.

Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Officer if you have questions about access to your medical record.

To inspect and/or copy your medical information maintained by Willis−Knighton, you must submit your request in writing to the Health Information Management Systems Department. You may be charged a fee for the administrative costs of retrieving, copying, mailing, and any other activities associated with your request.

Right to Request an Amendment: If you feel any of your medical information maintained by Willis−Knighton is incorrect or inaccurate, you may request an amendment of that information for as long as we maintain this information. In certain cases, we may deny your request for an amendment.

To request an amendment, your request must be made in writing and must include the reason for the request. All requests for amendment are to be submitted to the Health Information Management Department.

Willis−Knighton reserves the right to deny your request for amendment for any of the following reasons:

- The information is complete and accurate;
- We did not create the information;
- The person or entity that created the information is no longer available to make the amendment;
- The information is not part of the medical information kept by our facility; or
- The request pertains to information that you are not permitted to inspect and copy.

You have the right to file a statement of disagreement with us. In turn, we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Officer if you have questions about amending your medical record.

Right to an Accounting of Disclosures: This right applies to disclosures for purposes other than treatment, payment or health care operations as described in this Notice of Privacy Practices for a time frame of up to six years from the date of the request. It excludes routine disclosures, such as any we may have made to you, for a facility directory, to family members or friends involved in your care, or for notification purposes.

To request an accounting of disclosures, you must submit a written request to the Health Information Management Systems Department. Your request must state a time period, which may not exceed six years. You will not be charged for the first request for accounting within a twelve−month period; however, you may be charged a fee for the administrative costs of retrieving, copying, mailing, and any other activities associated with any additional requests for accounting. You will be notified of the costs involved and will have the option to withdraw your request at that time, before any costs are incurred.

Right to Request Restriction: You have a right to request that Willis−Knighton restrict the use or disclosure of any part of your Protected Health Information for the purposes of treatment, payment or health care operations. You may also request that your Protected Health Information be disclosed to family members or friends for notification purposes on an all or nothing basis. You must decide whether to grant disclosure to all family and friends, or to none.

You may request additional restrictions on the use or disclosure of information for treatment, payment or health care operations. We are *not* required to agree to the requested restriction except in the limited situation in which you or someone on your behalf pays in full for an item or service, and you request that information concerning such item or service not be disclosed to a health insurer.

WILLIS-KNIGHTON HEALTH SYSTEM

"SIGNATURE ON FILE" CARD FOR BOTH MEDICARE AND MEDIGAP

Medicare Services has designed a dual purpose Medicare/Medigap card for "Signature on File" requirements.

Providers may duplicate the form below and use it to obtain a "Signature on File" for both Medicare Part B and Medigap. Please remember that you must get approval from Medicare Services to use the "Signature on File" method of billing.

Name of Patient	HIC #
Name of Medigap Insurer	Medigap Policy #

I request that payment of authorized Medicare benefits be made either to me or on my behalf to (enter provider name) for any services furnished me by that provider. I authorize any holder of medical information about me to release the Centers for Medicare & Medicaid Services and it's agents any information needed to determine these benefits or the benefits paybale for related services.

I request payment of authorized Medigap benefits be made to this provider and also authorize any holder of medical information about me to release to the above named Medigap insurer any information needed to determine benefits payable or services from this provider.

Patient's Signature	Date Signed

PHYSICIAN SIGNATURE REQUIREMENTS
Medicare requires a legible identifier for services provided/ordered. The method used shall be hand written or electronic signature (stamp signatures are not acceptable) to sign an order or other medical record documentation for medical review purposes. Signature on File is acceptable.

Noted Exception: Facsimile of original written or electronic signatures are acceptable for the certifications of terminal illness for hospice.

Providers using electronic systems should recognize that there is a potential for misuse or abuse with alternate signature methods. Facsimile and hard copies of a physician's electronic signature must be in the patient's medical record for the certification of terminal illness for hospice. For example, providers need a system of software products which are protected against modification, etc., and should apply administrative procedures which are adequate and correspond to recognized standards and laws. The individual whose name is on the alternate signature method and the provider bears the responsibility for the authenticity of the information being attested to. Physicians should check with their attorney's and malpractice insurers in regard to the use of alternate signature methods.

AU977
Devised 04/2011

Right to Request Confidential Communications: You have the right to request to receive confidential communications from Willis−Knighton by alternative means or at an alternative location. For example, you may wish to be contacted only at work or by mail. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request.

This request must be made in writing to the Health Information Management Systems Department and must specify how and where you wish to be contacted.

Right to obtain a copy of this Notice: You have the right to obtain a copy of this Notice of Privacy Practices upon request. To receive a copy of this Notice, or any future revisions of the Notice, you may contact our Privacy Officer and request that a revised copy be sent to you in the mail or it is available online at www.wkhs.com. Additionally, you may also obtain a copy in the Admissions Office at the time of your next appointment.

3. Complaints

If you believe your privacy rights have been violated, you may file a complaint with Willis−Knighton or with the Secretary of Health and Human Services. You may also call the Willis−Knighton Compliance/Privacy Hotline at 1−888−884−2499 to file a complaint with us, or contact our Privacy Officer for further information about the complaint process. We will not retaliate against you for filing a complaint.

If you have any questions about this Notice, please contact our Privacy Officer, Jaf Fielder, at 1 (888) 884−2499, or by email at jfielder@wkhs.com. This Notice was published and becomes effective on **September 1, 2013.**

Revised 09/01/13

WILLIS-KNIGHTON HEALTH SYSTEM

"SIGNATURE ON FILE" CARD FOR BOTH MEDICARE AND MEDIGAP

Medicare Services has designed a dual purpose Medicare/Medigap card for "Signature on File" requirements.

Providers may duplicate the form below and use it to obtain a "Signature on File" for both Medicare Part B and Medigap. Please remember that you must get approval from Medicare Services to use the "Signature on File" method of billing.

Name of Patient	HIC #
Name of Medigap Insurer	Medigap Policy #

I request that payment of authorized Medicare benefits be made either to me or on my behalf to (enter provider name) for any services furnished me by that provider. I authorize any holder of medical information about me to release the Centers for Medicare & Medicaid Services and it's agents any information needed to determine these benefits or the benefits paybale for related services.

I request payment of authorized Medigap benefits be made to this provider and also authorize any holder of medical information about me to release to the above named Medigap insurer any information needed to determine benefits payable or services from this provider.

Patient's Signature	Date Signed

PHYSICIAN SIGNATURE REQUIREMENTS
Medicare requires a legible identifier for services provided/ordered. The method used shall be hand written or electronic signature (stamp signatures are not acceptable) to sign an order or other medical record documentation for medical review purposes. Signature on File is acceptable.

Noted Exception: Facsimile of original written or electronic signatures are acceptable for the certifications of terminal illness for hospice.

Providers using electronic systems should recognize that there is a potential for misuse or abuse with alternate signature methods. Facsimile and hard copies of a physician's electronic signature must be in the patient's medical record for the certification of terminal illness for hospice. For example, providers need a system of software products which are protected against modification, etc., and should apply administrative procedures which are adequate and correspond to recognized standards and laws. The individual whose name is on the alternate signature method and the provider bears the responsibility for the authenticity of the information being attested to. Physicians should check with their attorney's and malpractice insurers in regard to the use of alternate signature methods.

AU977
Devised 04/2011

WILLIS-KNIGHTON HEALTH SYSTEM

ASSIGNMENT OF BENEFITS

1. Hospital Care Consent: I/we consent to hospital services, treatment and diagnostic procedures by the hospital as may be deemed necessary or advisable by my physician and/or consultants selected by my physician. The consent to hospital care includes permission for x−ray examinations, laboratory procedures, I.V. treatments, hepatitis test administration of blood and blood products, injections, medications, recording, filming or video monitoring for internal purposes only, and hospital services rendered the patient under the general and special instruction of doctors. The patient acknowledges responsibility for any or all of these procedures. It is the hospital policy that the patient has the opportunity to discuss surgery and procedures with the patient's doctor before hand. The patient has the right to consent to surgery and procedures. Except in emergencies or unusual circumstances, the hospital does not allow its facilities to be used without this discussion and patient's consent. I voluntarily give my consent to hospital care and accept the condition of hospitalization listed.

2. Authorizations for Release of Information: The employees and agents of this hospital and copy services and electronic claims processing services under contract with this hospital and any third party billing agents for this hospital or any of its staff physicians involved with patient care are given permission to release any and all information relating to the patient, including but not limited to the medical record of the patient's hospitalization, to another healthcare provider if the patient was transferred to that facility from this hospital and to any and all insurance companies or other third−party paying or obligated to pay, in whole or in part, the charges incurred by the patient in this hospital; and they are also given permission to release the above described information to any agent or firm working for or with the above described insurance companies or other third−party payors for the purpose of performing pre−certification, concurrent and/or retrospective review and/or other utilization review of any kind.

3. Valuables: I understand and acknowledge that the hospital assumes no responsibility for personal possessions including cash, jewelry, bridgework, eyeglasses or any other personal possession which I choose to keep in my room. I have been advised that such valuables should be placed in the care of my family or deposited in the hospital vault located in the Business Office.

4. Safety Code for Hospital: Safety Codes for hospitals issued by the National Fire Protection Association prevent the use in the hospital of any electrical equipment or accessories until they have been safety checked by the hospital's electrical engineer. Exceptions to this rule are hair and blow dryers, curling irons, hot rollers, radios, clocks, electric razors, shavers, contact lens sterilizers, electric toothbrushes and calculators.

5. Payment Guaranty and Assignment of Insurance Benefits: I, the undersigned patient, guardian, and/or guarantor (hereinafter "Debtor") hereby promise to pay in full Willis−Knighton Health System (WKHS) customary charges for the goods and services rendered to the patient identified on the reverse side hereof during this period of hospitalization (hereinafter "Indebtedness''). Debtor acknowledges and agrees that, unless waived in full by WKHS as set forth below, the Indebtedness accruing during this hospitalization is due and payable in such amounts and at such times during this hospitalization as WKHS may, in its sole discretion, determine, that the entire Indebtedness is due and payable in full at discharge. I acknowledge that, upon proof of acceptable insurance coverage, WKHS, in its sole discretion, may reduce the amount of indebtedness due and payable during this hospitalizations and the balance due at discharge. In such event, I understand that all deductibles, co−insurance, non−covered charges and other items not paid by insurance or other third−party payors shall be due and payable during this period of hospitalization and upon discharge as set forth hereinabove. I acknowledge and agree that in the event that WKHS, in its sole discretion, accepts proof of insurance coverage, claims for payment for benefits will be filed on behalf of the Debtor and/or the insured and that these benefits will be considered by WKHS in determining the amounts due as set forth hereinabove. I understand and agree that WKHS will accept payments from third−party payors and insurers on behalf of the Debtor and apply such payment to the indebtedness to the extent that they are received. I acknowledge and agree that the filing of such insurance and other third−party claims is performed as a service by WKHS and in no way relieves me of the obligation to pay the Indebtedness as agreed herein above.

Patient hereby appoints WKMC as Patient's authorized representative to file any necessary claim appeal(s) on Patient's behalf. In consideration for this appointment. WKMC agrees only to collect only applicable copayments, deductibles, and coinsurance for covered benefits from the Patient and waives any right to collect any other payments related to those covered benefits from the Patient.

Debtor hereby absolutely assigns to WKHS all insurance benefits on all policies of insurance under which Debtor is an insured, whether hospital, medical, liability or other insurance, and also hereby absolutely assigns to WKHS the proceeds of any judgment or settlement of any claim against any third party and any and all other amounts which may be determined in any manner to be payable to Debtor in connection with any injury suffered by the patient which gives rise to the Indebtedness incurred during this period of treatment. I hereby authorize WKHS to obtain any and all information related to such injuries, including, but not limited to, accident reports and agree to cooperate with WKHS in connection with the procurement of any information or documents WKHS deems in its sole discretion, necessary or appropriate in connection with the assignment made pursuant to this paragraph. I hereby authorize and direct that all such payments and proceeds shall be made directly to WKHS under the terms of this assignment. Any receipts from WKHS shall be applied towards Indebtedness but such application shall not relieve the Debtor from the Debtor's obligation to pay any remaining portion to the Indebtedness. Debtor acknowledges and agrees that, to the extent that the Indebtedness has not been satisfied by such receipts, that portion of the Indebtedness for which payment has been deferred pursuant to the preceding paragraph shall be due and payable in full on the thirtieth day following the date of service. In the event that WKHS receives proceeds and/or payments in excess of the Indebtedness, WKHS may apply such excess payment to any outstanding Indebtedness of Debtor to WKHS arising out of any other period(s) of treatment as well as any attorneys' fees and expenses for which Debtor may be liable hereunder. In the event that all Indebtedness has been paid

Admission Date:

Admission Time:

WILLIS-KNIGHTON HEALTH SYSTEM

ASSIGNMENT OF BENEFITS

in full, then WKHS will refund the Debtor any such excess payment. Notwithstanding anything herein to the contrary, the assignments made hereby shall remain in full force and effect until the entire Indebtedness and any and all attorneys' fees and expenses for which Debtor may be liable have been paid in full. In the event that the Indebtedness is not paid when and as due as determined by WKHS hereunder, and the Indebtedness is placed in the hands of an attorney for purposes of collection, Debtor agrees to pay reasonable attorneys' fees, which are hereby acknowledged to be one−third (1/3) of the amount of the Indebtedness at the time the matter is placed in the hands of an attorney, plus any and all court costs and other expenses incurred in connection with the collection of the Indebtedness.

Financial assistance is available to all patients who meet the requirements of our charity care policy. Patients are encouraged to contact the Business Office if they have any concerns or need assistance in paying their bills. Our charity care policy is limited to hospital charges and does not include physician, anesthesiologist or professional charges that are not billed by the hospital. In addition, financial assistance is not offered for cosmetic, elective, experimental or other treatments and all hospital services must be ordered by your physician.

6. Assignment to Physicians: I understand that my physician as well as other physicians who treat me or otherwise involved in my care while a patient at the hospital are not employees or agents of the hospital and the hospital is not responsible for their actions. I further understand that my physician or other physicians will send me a separate bill for their services, in addition to the hospital bill. I hereby assign to all physicians who treat me the benefits due to me for these services covering medical and/or surgical expenses. I agree that should be the amount be insufficient to cover the entire medical/surgical expense, I will be responsible to said physicians for payment of the entire bill.

7. Medicare Consent: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act (SSA) is correct. I authorize Willis−Knighton Health System (WKHS) to provide (SSA) or its intermediaries with access to my medical/hospital record for the purpose of processing the Medicare claim for this or a related Medicare claim. I further request that WKHS provide such copies thereof as may be requested. Copies may be made by WKHS or its agents or contractors providing copy service and electronic claims processing services and said third party billing agents for hospital and staff physicians involved with patient care.

8. Champus/Medicare Notice: Champus/Medicare will not pay for private rooms unless medical justified, personal convenience items, diagnostic admissions or test or hospital stays not medically necessary. My signature below acknowledges my receipt of this information regarding Champus/Medicare from the hospital on the date indicated.

9. Willis−Knighton Health System (and our Medical Staff) will use and disclose your personal health information to treat you, to receive payment for the care we provide and for other health care operations. Healthcare operations generally include those activities we perform to improve the quality of care. We have prepared a detailed NOTICE OF PRIVACY PRACTICES to help you better understand our policies in regards to your personal health information. The terms of the notice may change with time and we will always post the current notice at our facilities, on our website and have copies available for distribution. I acknowledge that I have received a copy of the Notice of Privacy Practices.

This form has been fully explained to me. My signature reflects my understanding of the information contained herein. I further understand and acknowledge that all references to myself as the patient shall be deemed to apply as if rewritten in their entirety to a dependent for whom I am responsible for and/or who is unable to consent on their behalf for reasons indicated below.

I acknowledge that I have been informed of my rights and obligations as a patient.

Signature of Patient/Guardian	Date/Time	Guarantor	Date/Time	Witness	Date/Time

Print Name	Date of Birth	Print Name	Print Name

If Patient/Guarantor is unable to sign, I, _____ , do hereby state that I have been given the authority to sign for

_____ , either expressed or implied and that he or she is fully aware of this authority.

Signature of Authorized Party	Authorized Party's Relationship to the Patient	Date/Time	Witness	Date/Time

Admission Date:

Admission Time:

AD0005