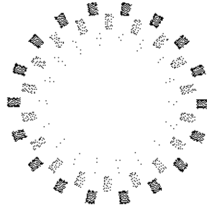

capitalhealth

Capital Health Center for Digestive Health

Dear Patient,

Enclosed you will find the paperwork that needs to be filled out prior to your appointment. ***Please arrive 15 minutes prior to your appointment time with the doctor***; this will give us time to register your information in our system. If you could have all the papers filled out and bring a list of medications that you use, a list of doctors that you see, your insurance card/s, and a photo ID, it would be greatly appreciated.

The address for Center for Digestive Health is:
Two Capital Way, Suite 380 Pennington, NJ 08534. ***If you are using a Navigation System or GPS (Global Positioning System) you might not find this address, please try putting in 408 Scotch Road Pennington, NJ 08534.***

You can utilize the free valet parking service located in the Main Hospital Entrance. Once you come in to the lobby, please proceed to the reception desk; the staff will give you directions to take the blue elevators to the 3rd floor and follow the signs to suite 380.

Thank you, we look forward to seeing you at your office visit appointment.

Sincerely,

Center for Digestive Health
Two Capital Way
Suite 380
Pennington, NJ 08534
Phone #: (609) 537-5000
Fax #: (609) 537-5050
www.capitalhealthgi.com

CAPITAL HEALTH CENTER FOR DIGESTIVE HEALTH

Date: ______________

PATIENT INFORMATION

Patient Name: ____ H. Phone :(   ) ________________

Address: ____

City: ______________________ State: _____ Zip: ________ Date of Birth: ________________

Soc Sec No: __________________________

Sex: ☐M ☐F **Marital Status:** ☐S ☐M ☐W ☐D ☐Sep

Ethnicity: ☐Hispanic/Latino ☐Non-Hispanic/Non-Latino ☐Unknown ☐Declined

Race: ☐Black/African American ☐White ☐Asian ☐American Indian/Alaska Native ☐Native Hawaiian/Other Pacific Islander ☐Unknown ☐Declined **Language:** ______________________

Cell Phone (   ) ______________________ E-Mail Address__________________________

Employer: ________________________________ W. Phone: (   ) ________________

Work Address: ____________________ City: ______________ State: _____ Zip: ________

Pharmacy Name/Phone #____________________Spouse/Partner: ____________________

Referred by: _______________________ Primary Care Physician: ____________________

Other Physicians: ____

____

Parent/Guardian: **(person to be billed if patient is under age 18)**

Name: ______________________________________ H. Phone ________________

Address: ____

City: ______________________ State: _______ ZIP: ____________

Date of Birth: __________ Soc Sec No: ____________________

Employer: ________________________________ W. Phone: (   ) ________________

Work Address: ____________________ City: ______________ State: _____ Zip: ________

MEDICAL INSURANCE INFORMATION

Primary Insurance Company: ___________________________Group#:________________

Policy/ID#: ________________________ Patient Relationship to Subsc: ________________

Subscriber's Name: _____________________Date of Birth: _______Soc Sec#:____________

Secondary Insurance Company: _________________________Group#:________________

Policy/ID#: ________________________ Patient Relationship to Subsc: ________________

Subscriber's Name: _____________________Date of Birth: _______Soc Sec#:____________

Other Insurances: ____

PLEASE TURN OVER

Subscriber information :(if different from Patient or Parent/Guardian): **__Primary** **__Secondary**

Address: ____

City: ______________________ State: __________ ZIP: ______________

Employer: __________________________ W. Phone: ( ) ______________

Work Address: ________________ City: ______________ State: _____ Zip: ________

In case of Emergency, Contact: ______________________ Relationship: __________

Home Phone: ( ) __________ Work Phone: ( ) __________ Other: ( ) __________

Please read, sign, and date the following to allow us to bill your insurance company for your medical care:

I have completed this form and certify that I am the Patient or duly authorized agent of the patient authorized to furnish the information requested. I understand that even though I may have some type of insurance coverage, I am responsible for payment for services. I authorize the release of medical history, information, or records concerning my diagnosis and treatment by CAPITAL HEALTH CENTER FOR DIGESTIVE HEALTH required to substantiate or explain insurance claims filed, and I authorize payment directly to CAPITAL HEALTH CENTER FOR DIGESTIVE HEALTH and permit a copy of this authorization to be used in place of the original. This authorization will remain in effect until revoked by me in writing.

If I have Medicare coverage, I request that payment of authorized Medicare benefits be made either to me or on my behalf to CAPITAL HEALTH CENTER FOR DIGESTIVE HEALTH for any services furnished to me by that physician or supplier. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information.) I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related service.

____ ______________

Signature of Patient or Authorized Person (Address/Relationship) DATE

If I have Medigap coverage, I request that payment of authorized Medigap benefits be made either to me or on my behalf to Capital Health Center for Digestive Health for any services furnished to me by that physician or supplier. I authorize any holder of Medicare information about me to release to

____

(Name of Medigap Insurer)

any information needed to determine these benefits payable for related services.

____ ______________

Signature of Patient or Authorized Person (Address/Relationship) DATE

****

I have read and reviewed the attached, and there are no changes to the information provided.

(To be re-signed once a year)

Signature: ______________________________ Date: ______________

Signature: ______________________________ Date: ______________

Signature: ______________________________ Date: ______________

Signature: ______________________________ Date: ______________

Name MRN Date

Capital Health Center for Digestive Health
New Patient Encounter Form

HISTORY - COMPLETED BY PATIENT, STAFF, OR PROVIDER

Please fill this form to your best ability.

1. Reasons for your visit today: ______________________________

____

2. Medical History: Please check all that apply

- ☐ Colon cancer or polyp
- ☐ Pancreatitis
- ☐ Esophageal Cancer
- ☐ Pancreas Cancer
- ☐ Barrett's Esophagus
- ☐ GERD or heartburn
- ☐ Heart attack or angina
- ☐ Pacemaker or Defibrillator
- ☐ Atrial Fibrillation
- ☐ High Blood Pressure
- ☐ Elevated cholesterol
- ☐ Blood Clot in leg or lung
- ☐ Diabetes
- ☐ Stroke
- ☐ Asthma or Lung Disease
- ☐ Kidney Disease
- ☐ Bleeding tendency

☐ Other Gastrointestinal diseases, please specify ______________________________

____

Other, please list: ______________________________

____

3. Please list ALL medication(s) (drugs, pills) you are taking, including dosage and frequency:

____________	____________	____________
____________	____________	____________
____________	____________	____________
____________	____________	____________

4. Previous Surgeries/Dates: Please check all that apply and list the date(s) to your best recollection

- ☐ Gallbladder ____________
- ☐ Colon ____________
- ☐ Esophagus or Stomach ____________
- ☐ Pancreas ____________

Name MRN Date

(Previous Surgeries/Dates, continued)

- ☐ Heart bypass surgery___________________
- ☐ Heart valve surgery___________________
- ☐ Hysterectomy___________________
- ☐ Other (please list)___________________

5. Allergies: Are you allergic to any medication(s)? ☐ No ☐ Yes. If yes, please list the medications you are allergic to and the type of reaction___________________

Are you allergic to any food(s)? ☐ No ☐ Yes: Please list: ___________________

6. What is your social history?

Marital Status: Single ☐, Divorced ☐, Married ☐, Widow/Widower ☐, With whom do you live?

Current occupation/Employer ___________________

Do you smoke? ________ How many packs a day? ________ For how many years? ________

Do you drink alcohol?________ How many drinks per day?_____ per week?_____ per month?________

Are you sexually active? ________ Do you use illicit drugs? ________ If yes, what kind? ________

7. What is the health status of your family?

Mother:___________________ Father:___________________

Brothers/Sisters:___________________

Family Illnesses:

History of Colon Cancer? ☐ no ☐ yes, Pancreatic cancer? ☐ no ☐ yes

Other cancer? ☐ no ☐ yes site ___________________

Name **MRN** **Date**

8. Review of systems: Do you have signs or symptoms in any of the following areas? Please check the appropriate box.

Yes	No	
		Constitutional
☐	☐	Fever, sweats or chills
☐	☐	Fatigue, anorexia
☐	☐	Weight loss >5 lbs.
		Skin:
☐	☐	Rashes
☐	☐	Jaundice
		Eyes:
☐	☐	Dry eyes or eye irritation
☐	☐	Change in vision
		Ears, Nose, Mouth and Throat:
☐	☐	Nose, sinus problems
☐	☐	Earache
☐	☐	Allergies
		Gastrointestinal
☐	☐	Heartburn or indigestion
☐	☐	Difficulty swallowing
☐	☐	Nausea or vomiting
☐	☐	Abdominal pain
☐	☐	Jaundice or hepatitis
		Genitourinary:
☐	☐	Frequent, difficult or painful urination
☐	☐	Nocturia
☐	☐	Irregular menstrual periods or vaginal bleeding
☐	☐	Urethra or vaginal discharge

Physician Comments - Review of Systems

Yes	No	
		Cardiovascular
☐	☐	Chest pain
☐	☐	Palpitations
☐	☐	Swelling of the ankles
☐	☐	Difficulty breathing upon lying down
		Respiratory
☐	☐	Shortness of breath
☐	☐	Cough
☐	☐	Sputum production
☐	☐	Snoring
☐	☐	Dry mouth, mouth ulcers
☐	☐	Sore throat
		Psychiatric:
☐	☐	History of anxiety disorder or depression
☐	☐	Sleep disturbances
		Neurological:
☐	☐	Headache
☐	☐	Focal weakness or numbness
☐	☐	Loss of consciousness
☐	☐	Dizziness, faintness
		Musculoskeletal:
☐	☐	Muscle aches
☐	☐	Arthritis or arthralgias

Other Symptoms: Please list

I have personally reviewed the information recorded in the above three pages

Attending Signature ____________________________ Date ___________________

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Center for Digestive Health

Two Capital Way
Suite 380
Pennington, New Jersey 08534
Tel.: 609 537 5000
Fax: 609 537 5050
www.capitalhealthGI.com

SPECIALIST INFORMATION

Please list your primary care physician as well as any specialist information below in the subsequent sections such as cardiologist (heart doctor), rheumatologist (arthritis doctor), endocrinologist (diabetes doctor), neurologist (stoke or MS doctor), etc.....This way we can keep all of your physicians informed about your health. This form will be updated EVERY year and we will ask for your signature verifying our records are correct. Thank you in advance for your anticipated cooperation.

PATIENT NAME: ______________________ DOB:________ DATE:____________________

Primary care physician:____

Address:____

City:____________________ State:______________ Zip code:____________________

Tele: (____)____________________ Fax:(____)______________________________

Specialist #1:______________________________ Specialty:____________________

Address:____

City:____________________ State:______________ Zip code:____________________

Tele: (____)____________________ Fax:(_____)______________________________

Specialist #2:______________________________ Specialty:____________________

Address:____

City:____________________ State:______________ Zip code:____________________

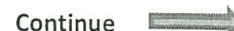
Tele: (_____)____________________ Fax:(_____)______________________________

Specialist #3:______________________________ Specialty:____________________

Address:____

City:____________________ State:______________ Zip code:____________________

Tele: (____)____________________ Fax:(______)______________________________

Continue 

Patient Signature & Initials:______________________________ Date:____________________

Patient Initials:____________ Date:__________ Patient Initials:____________ Date:__________
Patient Initials:____________ Date:__________ Patient Initials:____________ Date:__________

Specialist #4:______________________________ Specialty:____________________

Address:____

City:____________________State:______________ Zip code:____________________

Tele: (____)____________________________Fax:(______)____________________________

Specialist #5:______________________________ Specialty:____________________

Address:____

City:____________________State:______________ Zip code:____________________

Tele: (____)____________________________Fax:(______)____________________________

Specialist #6:______________________________ Specialty:____________________

Address:____

City:____________________State:______________ Zip code:____________________

Tele: (____)____________________________Fax:(______)____________________________

Specialist #7:______________________________ Specialty:____________________

Address:____

City:____________________State:______________ Zip code:____________________

Tele: (____)____________________________Fax:(______)____________________________

Specialist #8:______________________________ Specialty:____________________

Address:____

City:____________________State:______________ Zip code:____________________

Tele: (____)____________________________Fax:(______)____________________________

Specialist #9:______________________________ Specialty:____________________

Address:____

City:____________________State:______________ Zip code:____________________

Tele: (____)____________________________Fax:(______)____________________________

CAPITAL HEALTH SYSTEM

ACKNOWLEDGEMENT OF RECEIPT

NOTICE OF PRIVACY PRACTICES

I, ____, acknowledge that I have received a copy of Capital Health System's Joint Notice of Privacy Practices.

____

(sign name) **(date)**

Living Will:

Do you have a Living Will or Power of Attorney? YES NO

If YES, please furnish us with a copy of your medical chart or allow us to make a copy to attach to your chart. Thank you.

If NO, would you like more information regarding this subject? YES NO

Contact Information:

When we need to contact you about test results, prescription refills, referrals, etc. can we leave a message on your:

Home numbers: ______________________

Cell numbers: ________________________

Center for Digestive Health has permission to speak to the following on my behalf: ____

(family member or friend)

I ____ agree to the above.

Patient Name: _______________________**DOB**_____________**Date:**______

CAPITAL HEALTH

CENTER FOR DIGESTIVE HEALTH

2 CAPITAL WAY SUITE 380

PENNINGTON, NJ 08534

Medication History & Medication Benefits Consent

I give permission for Center for Digestive Health to obtain my current Medications and Medication History from the Surescripts Pharmacy Clearinghouse.

I understand that this information will be stored in my Electronic Health Record and may be used in the normal course of my treatment at Center for Digestive Health.

____

Patient Signature and Date

Center for Digestive Health
2 Capital Way
Suite 380
Pennington, NJ 08534
Tel.: 609-537-5000
Fax: 609-537-5050

Authorization for Patient Access/Release of Health Information

Patient Name:	Medical Record #:
Date of Birth:	Phone #:
Home Address: City: State: Zip:	

1. Type of Request: I hereby request the following:

- [ ] Access to review my original medical record
- [ ] Release/Disclosure of my health information, as requested below
- [ ] Request my medical records from another facility — *Name of Facility:*

2. Description of Information To Be Released: *(Check ALL that apply)*

[ ] Abstract* (defined below)	[ ] Entire Medical Record	[ ] History and Physical	[ ] Operative Reports
[ ] Immunization Record	[ ] ER Record	[ ] Progress Notes	[ ] X-ray Reports
[ ] Outpatient Records	[ ] Consultation Reports	[ ] EKG/EEG	[ ] Discharge Summary
[ ] Treatment Record	[ ] Labs	[ ] Other *(specify)*:	
Date of Service			

*(*Abstract is defined as the face sheet, discharge summary, history and physical exam, consultation report, operative report, test results)*

I understand that the specific information to be released may include reference to alcohol abuse, drug abuse, AIDS/HIV infection, sexually transmitted diseases, tuberculosis, and/or psychiatric conditions and the treatment of any of these disorders. If this information is documented in my medical record, I agree to the release of it.

3. Disclose/Send Information To:

- [ ] Myself *(the patient or authorized representative)*
- [ ] To Organization/Individual below:

Organization:	Individual Name:	Phone #:
Street Address: City:	State: Zip Code:	[ ] Please Mail [ ] Please prepare for pick-up

4. Purpose of Release: I authorize Capital Health to release my health information for the following specific purpose:

5. Term/Expiration:
I understand that by law, I do not have to release this information and I choose to do so voluntarily. I may cancel this authorization by providing a written revocation to Capital Health, Health Information Management Department at either campus. This authorization will automatically expire twelve (12) months from the date listed below. *I understand that I may refuse to sign this form and that my health care and the payment for my health care will not be affected if I do not sign this form. I understand that once this information is disclosed, it is no longer protected by Federal Privacy Regulations and that the information could be re-disclosed without my permission.*

6. Fees:
Capital Health charges a reasonable fee for retrieval of medical records and preparation of photocopies for purposes other than patient care.

Signature of Patient or Patient's Representative   Date

Relationship to Patient   Witness Signature

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Minds Advancing Medicine

PATIENT PORTAL
USER AGREEMENT

Welcome to the Capital Health Patient Portal. The Patient Portal allows patients who are registered users to communicate with their health care providers and to access certain health information.

All registered users of the Patient Portal are subject to the terms and conditions of use (these "Terms and Conditions") found at www.capitalhealth.org/myportal. Please read the Terms and Conditions carefully before accessing or using any part of the Patient Portal. By accessing or using the Patient Portal, you agree that you have read, understand and agree to be bound by the Terms and Conditions. It is important to review the Terms and Conditions periodically as we may modify them at any time, and you agree that such modifications are effective and binding immediately upon posting of the modified version. If you do not wish to agree to the Terms and Condition or this Agreement, do not access or use any part of the Patient Portal

Specifically, in addition to the Terms and Conditions, you acknowledge, and agree to, the following:

1. Your Portal ID and Password must be used in order to access your account on the Patient Portal. You agree that **you will not share your Portal ID and Password with anyone** unless specifically authorized by the Practice. You acknowledge and understand that if you share your Portal ID and Password your and/or your child's information will be available to that person and anyone else with whom they might share your password.

2. You understand that the Patient Portal cannot be used for urgent or emergency matters. You may contact the Practice by phone or in person for urgent matters and **you should contact 9-1-1 for emergencies.**

3 Your messages may become part of your medical record, and therefore, such messages will be secured, accessible and disclosed in the same manner as the rest of your medical record (e.g., such information may be disclosed to your insurance company if they are conducting an audit or validating a claim).

4. You agree that you will not (a) use the Patient Portal to violate the legal rights of others or to violate the laws of any jurisdiction; (b) upload or send any defamatory, offensive, harassing, violent or otherwise objectionable material through the Patient Portal; (c) intercept or attempt to intercept electronic email not intended for you; (d) misrepresent an affiliation with any person or organization; (e) transmit any advertisements or solicitations of business through the Patient Portal; (f) upload or transmit files that contain a virus or corrupted data; (g) post "spam," transmit chain letters or engage in other similar activities; (h) violate or attempt to violate the security of the Patient Portal, including, without limitation, by accessing data not intended for you, logging into a server or account that you are not authorized to access, attempting to probe, scan, spider or test the vulnerability of any system or network, breaching security or authentication measures without proper authorization; or (i) engage in any other conduct that restricts or inhibits anyone's use of the Patient Portal, or which, as determined by the Practice, may harm the Practice or users of the Patient Portal or expose them to liability.

5. You will inform the Practice if you change your e-mail address.

6. Although the Practice has implemented security in the Patient Portal to protect the confidentiality of your information, the Practice cannot protect against each and every potential intrusion. You expressly assume the sole risk of any unauthorized disclosure or intentional intrusion or of any delay, failure, interruption or corruption of data or other information transmitted in connection with the use of the Patient Portal.

7. You understand that the Practice does not assume any liability for the materials, information and opinions provided on, or available through, the Patient Portal. You agree that reliance on the content of the Patient Portal is solely at your own risk. You understand that the Practice disclaims any liability for injury or damages resulting from the use of the Patient Portal.

8. You agree to indemnify and hold harmless the Practice and its officers, directors, employees, agents, affiliates, third party information providers, licensors and others involved in the delivery of products, services or information over the Patient Portal, from and against any and all liabilities, expenses, damages and costs, including reasonable attorneys' fees, arising from any violation by you of this Agreement or your use of the Patient Portal or any products, services or information obtained from the Patient Portal.

9. You will inform your Practice if you lose your password or if you believe that there has been an unauthorized access to your account on the Patient Portal.

If the Practice determines that you have violated this agreement and/or abused the use of this service, we reserve the right, at our sole discretion, to discontinue your use of the Patient Portal. You will be notified if your Patient Portal service is discontinued.

☐ I certify that I have read, fully understand and agree to abide by this Agreement.

____________________________ ____________________

Signature Today's Date

____________________________ ____________________

Printed name DOB

Missed Appointment Policy

Our goal is to provide quality individualized medical care in a timely manner. "No-shows", and late cancellations inconvenience those individuals who need access to medical care in a timely manner. We would like to remind you of our office policy regarding missed appointments. This policy enables us to better utilize available appointments for our patients in need of medical care.

Cancellation of an Appointment

In order to be respectful of the medical needs of other patients, please be courteous and call The Center for Digestive Health promptly if you are unable to show up for an appointment. This time will be reallocated to someone who is in need of treatment. If it is necessary to cancel your scheduled appointment, we require that you call at least **24 hours** in advance. Appointments are in high demand, and your early cancellation will give another person the possibility to have access to timely medical care.

How to Cancel Your Appointment

To cancel appointments, please call 609-537-5000. If you do not reach the receptionist you may leave a detailed message on the voice mail. If you would like to reschedule your appointment, please leave your phone number. We will return your call and give you the next available appointment time.

Late Cancellations: A late cancellation is considered when a patient fails to cancel their scheduled appointment with a **24 hour** advance notice.

No Show Policy: A "no-show" is someone who misses an appointment without cancelling it in an adequate manner. A failure to be present at the time of a scheduled appointment will be recorded in the your medical record as a "no-show".

- Missed office visit appointment: $50.00 fee will be billed to your account
- Missed procedure appointment: $100.00 fee will be billed to your account
- Third missed appointment or procedure: $100.00 fee will be billed to your account and you may be discharged from our practice

JOINT PRIVACY NOTICE

THIS JOINT 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.

INTRODUCTION

This Joint Notice is being provided to you on behalf of Capital Health Medical System Hopewell (**"Capital Health"**) and the practitioners with clinical privileges that work at Capital Health's facilities (collectively referred to herein as "We" or "Our".

We understand that your medical information is private and confidential. Further, we are required by law to maintain the privacy of "protected health information." "Protected health information" or PHI includes any individually identifiable information that we obtain from you or others that relates to your past, present or future physical or mental health, the health care you have received, or payment for your health care. We will share protected health information with one another, as necessary, to carry out treatment, payment or health care operations relating to the services to be rendered at Hospital facilities.

As required by law, this notice provides you with information about your rights and our legal duties and privacy practices with respect to the privacy of protected health information. This notice also discusses the uses and disclosures we will make of your protected health information. We must comply with the provisions of this notice as currently in effect, although we reserve the right to change the terms of this notice from time to time and to make the revised notice effective for all protected health information we maintain. You can always request a written copy of our most current privacy notice from Capital Health's Chief Privacy Officer as described at the end of this notice or you can access it on our website at www.Capitalhealth.org.

Understanding Your Health Record/Information

Each time you visit a Capital Health facility we make a record of your visit. Most often, this record contains notes about your symptoms, results of physical examinations and tests, diagnosis, treatment, and plans for future care or treatment. This information, sometimes referred to as your health or medical record, serves as a:

- basis for planning your care and treatment
- means of communication to other health professionals who may care for you
- legal document telling about the care you received
- means by which you or a third party payer (insurer or others legally responsible to pay for your medical care) can be sure that services billed were actually given to you
- a tool for educating health care givers (for example: doctors, nurses, dieticians)
- a source of data for medical research (data is not identified with you)
- a source of information for public health officials charged with improving the health of the public
- a source of data for hospital planning and marketing (in a format that does not specifically identify you)
- a tool with which we can use to improve the care we give and the results we achieve

Understanding what information is in your medical records and how your health information is used helps you to:

- Make sure it is correct;
- Better understand who, what, where and why others may see and use your health information;
- Make informed choices when you permit others to see your personal health information;

PERMITTED USES AND DISCLOSURES

We can use or disclose your protected health information for purposes of *treatment, payment and health care operations.* For each of these categories of uses and disclosures, we have provided a description and an example below. However, not every particular use or disclosure in every category will be listed.

- *Treatment* means the provision, coordination or management of your health care, including consultations between health care providers relating to your care and referrals for health care from one health care provider to another. 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 contact a physical therapist to create the exercise regimen appropriate for your treatment.

- *Payment* means the activities we undertake to obtain reimbursement for the health care provided to you, including billing, collections, claims management, determinations of eligibility and coverage and other utilization review activities. For example, we may need to provide PHI to your Third Party Payor to determine whether the proposed course of treatment will be covered or if necessary to obtain payment. Federal or State law may require us to obtain a written release from you prior to disclosing certain specially protected health information for payment purposes, and we will ask you to sign a release when necessary under applicable law.

- *Health care operations* means the support functions of the Hospital, related to *treatment* and *payment*, such as quality assurance activities, case management, receiving and responding to patient comments and complaints, physician reviews, compliance programs, audits, business planning, development, management and administrative activities. For example, we may use your protected health information to evaluate the performance of our staff when caring for you. We may also combine health information about many patients to decide what additional services we should offer, what services are not needed, and whether certain new treatments are effective. We may also disclose PHI for review and learning purposes. In addition, we may remove information that identifies you so that others can use the de-identified information to study health care and health care delivery without learning who you are.

OTHER USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

In addition to using and disclosing your information for treatment, payment and health care operations, we may use your protected health information in the following ways:

- We may contact you to provide appointment reminders for your treatment or medical care.
- We may contact you to tell you about or recommend possible treatment alternatives or other health-related benefits and services that may be of interest to you.
- We may disclose to your family or friends or any other individual identified by you protected health information directly related to such person's involvement in your care or the payment for your care. We may use or disclose your protected health information to notify, or assist in the notification of, a family member, a personal representative, or another person responsible for your care, of your location, general condition or death. If you are present or otherwise available, we will give you an opportunity to object to these disclosures, and we will not make these disclosures if you object. If you are not present or otherwise available, we will determine whether a disclosure to your family or friends is in your best interest, taking into account the circumstances and based upon our professional judgment.
- 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 and your religious affiliation. The directory information, except for your religious affiliation, may 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 do not ask for you by name. This will allow your family, friends, and clergy to visit you in the Hospital. You may request that your information not be listed in the directory.
- When permitted by law, we may coordinate our uses and disclosures of protected health information with public or private entities authorized by law or by charter to assist in disaster relief efforts.
- We will allow your family and friends to act on your behalf to pick-up filled prescriptions, medical supplies, X-rays, and similar forms of protected health information, when we determine, in our professional judgment that it is in your best interest to make such disclosures.
- We may contact you as part of our fund-raising and marketing efforts as permitted by applicable law.
- We may use or disclose your protected health information for research purposes, subject to the requirements of applicable law. For example, a research project may involve comparisons of the health and recovery of all patients who received a particular medication. All research projects are subject to a special approval process which balances research needs with a patient's need for privacy. When required, we will obtain a written authorization from you prior to using your health information for research.
- We will use or disclose protected health information about you when required to do so by applicable law.

***NOTE*:** **IN ACCORDANCE WITH APPLICABLE LAW, WE MAY DISCLOSE YOUR PROTECTED HEALTH INFORMATION TO YOUR EMPLOYER IF WE ARE RETAINED TO CONDUCT AN EVALUATION RELATING TO MEDICAL SURVEILLANCE OF YOUR WORKPLACE OR TO EVALUATE WHETHER YOU HAVE A WORK-RELATED ILLNESS OR INJURY. YOU WILL BE NOTIFIED OF THESE DISCLOSURES BY YOUR EMPLOYER OR THE HOSPITAL AS REQUIRED BY APPLICABLE LAW.**

Note: incidental uses and disclosures of PHI sometimes occur and are not considered to be a violation of your rights. Incidental uses and disclosures are by-products of otherwise permitted uses or disclosures which are limited in nature and cannot be reasonably prevented.

SPECIAL SITUATIONS

Subject to the requirements of applicable law, we will make the following uses and disclosures of your protected health information:

- Organ and Tissue Donation. If you are an organ donor, we may release health 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 health information about you as required by military command authorities. We may also release health information about foreign military personnel to the appropriate foreign military authority.
- Worker's Compensation. We may release health information about you for programs that provide benefits for work-related injuries or illnesses.
- Public Health Activities. We may disclose health information about you for public health activities, including disclosures:
  - to prevent or control disease, injury or disability;
  - to report births and deaths;
  - to report child abuse or neglect;
  - to persons subject to the jurisdiction of the Food and Drug Administration (FDA) for activities related to the quality, safety, or effectiveness of FDA-regulated products or services and to report reactions to medications or problems with products;
  - 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;
  - to notify the appropriate government authority if we believe that an adult patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if the patient agrees or when required or authorized by law.

- Health Oversight Activities. We may disclose health information to Federal or State agencies that oversee our activities. These activities are necessary for the government to monitor the health care system, government benefit programs, and compliance with civil rights laws or regulatory program standards.

- Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose health information subject to certain limitations.

- Law Enforcement. We may release health 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 under certain limited circumstances;
  * About a death we believe may be the result of criminal conduct;
  * About criminal conduct on our premises; and
  * In emergency circumstances, to report a crime, the location of the crime or the victims, or the identity, description or location of the person who committed the crime.

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

- National Security and Intelligence Activities. We may release health information about you to authorized Federal officials for intelligence, counterintelligence, other national security activities authorized by law or to authorized Federal officials so they may provide protection to the President or foreign heads of state.

- Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release health 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.

- Serious Threats. As permitted by applicable law and standards of ethical conduct, we may use and disclose protected health information if we, in good faith, 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 or is necessary for law enforcement authorities to identify or apprehend an individual.

HIV-RELATED INFORMATION, GENETIC INFORMATION, ALCOHOL AND/OR SUBSTANCE ABUSE RECORDS, MENTAL HEALTH RECORDS AND OTHER SPECIALLY PROTECTED HEALTH INFORMATION MAY ENJOY CERTAIN SPECIAL CONFIDENTIALITY PROTECTIONS UNDER APPLICABLE STATE AND FEDERAL LAW. ANY DISCLOSURES OF THESE TYPES OF RECORDS WILL BE SUBJECT TO THESE SPECIAL PROTECTIONS.

OTHER USES OF YOUR HEALTH INFORMATION

Certain uses and disclosures of protected health information not covered by this notice or the laws that apply to us will be made only with your permission in a written authorization. You have the right to revoke that authorization at any time, provided that the revocation is in writing, except to the extent that we already have taken action in reliance on your authorization.

YOUR RIGHTS

1. You have the right to request restrictions on our uses and disclosures of protected health information for treatment, payment and health care operations. However, we are not required to agree to your request unless the disclosure is to a health plan in order to receive payment, the PHI pertains solely to your health care items or services for which you have paid the bill in full, and the disclosure is not otherwise required by law. To request a restriction, you must submit a completed Capital Health's Request for Restrictions on Use and Disclosure of PHI form to Capital Health's Health Information Management Department. Copies of the form at available at the CHS' Health Information Management Department.

2. You have the right to reasonably request to receive confidential communications of protected health information by alternative means or at alternative locations. To make such a request you must submit a completed Capital Health Request for Alternate Delivery of PHI form to Capital Health's Patient Access Department. You can obtain a copy of the form from Capital Health's Patient Access Department.

3. You have the right to inspect and copy the protected health information contained in your medical and billing records and in any other Hospital records used by us to make decisions about you, except:

(i) for psychotherapy notes, which are notes that have been recorded by a mental health professional documenting or analyzing the contents of conversations during a private counseling session or a group, joint or family counseling session and that have been separated from the rest of your medical record;

(ii) for information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding;

(iii) for protected health information involving laboratory tests when your access is restricted by law;

(iv) if you are a prison inmate, obtaining a copy of your information may be restricted if it would jeopardize your health, safety, security, custody, or rehabilitation or that of other inmates, or the safety of any officer, employee, or other person at the correctional institution or person responsible for transporting you;

(v) if we obtained or created protected health information as part of a research study, your access to the health information may be restricted for as long as the research is in progress, provided that you agreed to the temporary denial of access when consenting to participate in the research;

(vi) for protected health information contained in records kept by a Federal agency or contractor when your access is restricted by law; and

(vii) for protected health information obtained from someone other than us under a promise of confidentiality when the access requested would be reasonably likely to reveal the source of the information.

In order to inspect and copy your health information, you must submit a completed Capital Health PHI Access Request form to Capital Health's Health Information Management Department. Copies of the form are at available at Capital Health's Health Information Management Department. If you request a copy of your health information, we may charge you a fee for the costs of copying and mailing your records, as well as other costs associated with your request.

We may also deny a request for access to protected health information under certain circumstances if there is a potential for harm to yourself or others. If we deny a request for access for this purpose, you have the right to have our denial reviewed in accordance with the requirement of applicable law.

4. You have the right to request an amendment to your protected health information, but we may deny your request for amendment, if we determine that the protected health information or record that is the subject of the request:

(i) was not created by us, unless you provide a reasonable basis to believe that the originator of protected health information is no longer available to act on the requested amendment;

(ii) is not part of your medical or billing records or other records used to make decisions about you;

(iii) is not available for inspection as set forth above; or

(iv) is accurate and complete.

In any event, any agreed upon amendment will be included as an addition to, and not a replacement of, already existing records. In order to request an amendment to your health information, you must submit a completed Capital Health Request for Amendment to Medical Record form to Capital Health's Health Information Management Department. Copies of the form are available at the Health Information Management Department.

5. You have the right to receive an accounting of disclosures of protected health information made by us to individuals or entities other than to you for the six prior years, except for disclosures:

(i) to carry out treatment, payment and health care operations as provided above;

(ii) incidental to a use or disclosure otherwise permitted or required by applicable law;

(iii) pursuant to a written authorization obtained from you;

(iv) for the Hospital's directory or to persons involved in your care or for other notification purposes as provided by law;

(v) for national security or intelligence purposes as provided by law;

(vi) to correctional institutions or law enforcement officials as provided by law;

(vii) as part of a limited data set as provided by law; or

To request an accounting of disclosures of your health information, you must submit a completed Capital Health request for Accounting form to Capital Health's Health Information Management Department. Copies of the form are available at Capital Health's Health Information Management Department. The first accounting you request within a twelve (12) month period will be free. For additional accountings, we may charge you for the costs of providing the list. We will notify you of the costs involved, and you may choose to withdraw or modify your request at that time before any costs are incurred.

6. You have the right to receive a notification, in the event that there is a breach of your unsecured protected health information, which requires notification under the Privacy Rule.

COMPLAINTS

If you believe that your privacy rights have been violated, you should immediately contact Capital Health's Chief Privacy Officer at 1-877-482-2908 or at (609) 394-6105. We will not take action against you for filing a complaint. You also may file a complaint with the Secretary of United States Department of Health and Human Services. You may also contact Capital Health's Chief Privacy Officer if you have questions or would like further information about this notice.

EFFECTIVE DATE

This notice is effective as of September 23, 2013.