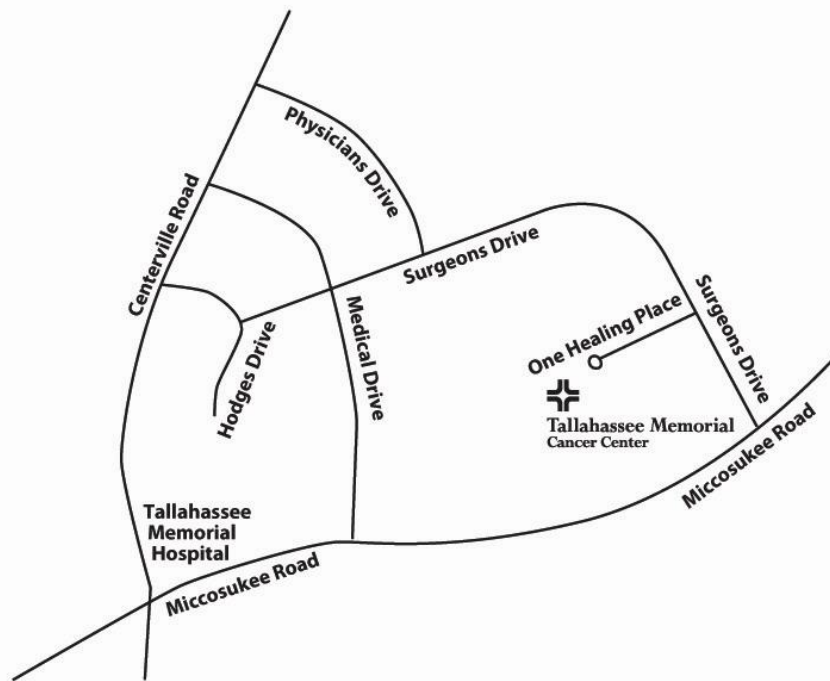


Tallahassee Memorial Cancer Center



Tallahassee Memorial Cancer Center

1775 One Healing Place, Tallahassee, Florida

Located near the corner of Miccosukee and Surgeons Drive

Phone (850) 431-ICAN (4226)

We are pleased to announce that the following services are now being performed at our new Cancer Center facility:

- Radiation Oncology
- Navigation and Counseling Services
- Survivorship Programming
- Image Recovery Services

TMH *Your Hospital for Life™*



**Tallahassee Memorial
Cancer Center**

TMH.org



Tallahassee Memorial Cancer Center

Tallahassee Memorial HealthCare

Dear Patient:

Welcome to Tallahassee Memorial Cancer Center's Radiation Oncology Department. We look forward to meeting and learning more about you during your first appointment.

Please complete the following forms and bring them with you on the day of your appointment. This will allow us to process your paperwork in a timely manner. If you have any questions or need assistance please do not hesitate to call us at the number below.

*Please arrive 30 minutes early to allow us to review all forms.

In addition to these forms, please bring your insurance card(s) and a valid photo ID.

Thank you for your assistance in advance. We look forward to seeing you.

Sincerely,
Front Office and Registration Staff
Tallahassee Memorial Cancer Center
Radiation Oncology Department
1775 One Healing Place
Tallahassee, FL 32308
Phone: (850) 431-5255
Fax: (850) 431-3989



Tallahassee Memorial Cancer Center

Tallahassee Memorial HealthCare

NEW PATIENT / FOLLOW-UP DEMOGRAPHICS

PATIENT: Please complete all of the following information and return to the receptionist along with your insurance cards and photo identification to copy for our records.

Patient Name: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home #: _____ Work #: _____ Cell or Other #: _____

Social Security #: _____ - _____ - _____ Race: _____ Marital Status: _____

Employer: _____

Employer Address: _____

City: _____ State: _____ Zip Code: _____

Insurance #1: _____ Policy #: _____

Group #: _____ Policy Holders Name: _____

Policy Holders DOB: _____ Relationship to Insured: _____
(Self/Spouse/Parent/Guardian)

Insurance #2: _____ Policy #: _____

Group #: _____ Policy Holders Name: _____

Policy Holders DOB: _____ Relationship to Insured: _____
(Self/Spouse/Parent/Guardian)

NEXT OF KIN / EMERGENCY CONTACT

Name: _____ Relationship to Patient: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home #: _____ Work #: _____ Cell or Other #: _____

Employer Address: _____

City: _____ State: _____ Zip Code: _____

I certify that the information above is accurate to the best of my knowledge.

Patient Signature

Date



Tallahassee Memorial Cancer Center

Tallahassee Memorial HealthCare

Information Release

The physicians and staff of Radiation Oncology consider all patient information confidential. Please list all individuals with whom we may discuss your medical condition, test results, and/or treatment plan. Please sign below indication you have given this authorization.

YOU MAY DISCUSS MY TREATMENT WITH:

1. _____ Relationship _____
2. _____ Relationship _____
3. _____ Relationship _____
4. _____ Relationship _____

Signed: _____ Date: _____

Acknowledgement of Notice of Privacy Policy

I have received a copy of Tallahassee Memorial Healthcare's Notice of Privacy Policy.
 I DO NOT I DO wish to make further restrictions on the use of my protected health information.

Additional restrictions: _____

Patient Signature: _____ Date: _____

EMERGENCY NOTIFICATION:

NAME _____ PHONE # _____

NAME _____ PHONE # _____

OFFICE USE ONLY

Reviewed by: _____,RN Review by: _____,MD

Date: _____ Date: _____

****SCAN AS SINGLE DOCUMENT IN ARIA****



Tallahassee Memorial Cancer Center

Tallahassee Memorial HealthCare

PATIENT PROFILE

Date: _____

Sex: __ Male __ Female

Name (Last, First): _____

Date of Birth: _____

PAST MEDICAL HISTORY:

Have you ever had any of the following? (Please Check)

<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Pacemaker/Defibrillator
<input type="checkbox"/> Heart Rhythm Disease	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Lupus	<input type="checkbox"/> Heart Failure
<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Osteoarthritis	<input type="checkbox"/> Cirrhosis	<input type="checkbox"/> Heart Rhythm Disease
<input type="checkbox"/> Emphysema or COPD	<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> Colitis	<input type="checkbox"/> Heart Attack
<input type="checkbox"/> Asthma	<input type="checkbox"/> Stomach Ulcers	<input type="checkbox"/> Gallstones	<input type="checkbox"/> Coronary Artery Disease
<input type="checkbox"/> Acid Reflux Disease	<input type="checkbox"/> Clotting Problems	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Sjogren's Syndrome
<input type="checkbox"/> Pancreatitis	<input type="checkbox"/> Diverticulitis	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Low Thyroid	<input type="checkbox"/> Scleroderma	<input type="checkbox"/> Seizures	<input type="checkbox"/> Stroke
<input type="checkbox"/> Asbestos Exposure			
<input type="checkbox"/> OTHER:			

Have you had Chemotherapy? __ YES __ NO Why? Which drugs? Where did you receive it?

Have you had Radiation Therapy? __ YES __ NO When? Why? # of Treatments? Where?

List all past surgeries: _____

FAMILY HISTORY:

History of cancer in any family members? __ YES __ NO

If "yes" please explain: _____

SOCIAL HISTORY:

Education: Check last year completed:

Grade School __1-5 __6-8 High School __9 __10 __11 __12

College__ Masters__ Doctorate__

OCCUPATION: CHECK ONE OR MORE:

__Employed/Self Employed If employed, describe the work you do: _____

__Student __Retired __Unemployed __Disabled

If retired, your occupation prior to retirement: _____

If disabled, describe disability and date work stopped: _____



Tallahassee Memorial Cancer Center

Tallahassee Memorial HealthCare

ALCOHOL & TOBACCO USE:

Do you smoke cigarettes? YES NO # packs per day: _____ for how many yrs? _____

Have you ever smoked for period of five (5) or more years? YES NO # packs per day: _____ How many years? _____

Are you interested in stopping? YES NO

Are you an ex-smoker? YES NO If "yes" when did you quit? _____

Regular alcohol/beer intake: YES NO Per Day? _____ Per Month? _____

Are you an ex-drinker? YES NO If "yes" when did you quit? _____

SOCIAL ISSUES: If "Yes", Please Explain

Do you live alone? YES NO _____

If not, who lives with you? _____

Do you have transportation issues? YES NO _____

Do you need assistance with you activities of daily living? YES NO _____

Do you have financial concerns? YES NO _____

Concerned about your coping abilities, or your family's ability to cope? YES NO _____

Do you have any Marital concerns? YES NO _____

Have you ever been the subject of violence in you home? YES NO _____

MEDICATIONS: List any medications you are taking, including vitamins and all non-prescription drugs. Copy names and dosages of medication from the prescription label.

Name of Medication	How Often	Dosage (mgs/tablets)
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____
7. _____	_____	_____
8. _____	_____	_____
9. _____	_____	_____
10. _____	_____	_____

ALLERGIES: Please list any medication to which you are allergic. Include any reaction you have had to x-ray dyes (Iodine) or Shellfish. NO KNOWN ALLERGIES

MEDICATION	TYPE OF REACTION
1. _____	_____
2. _____	_____
3. _____	_____



Tallahassee Memorial Cancer Center

Tallahassee Memorial HealthCare

REVIEW OF SYMPTOMS: In the past **3 months**, have you experienced any of the following:

CONSTITUTIONAL

- YES NO Lack of appetite
- YES NO Fever
- YES NO Lethargy/Fatigue
- YES NO Night sweats/chills
- YES NO Weight Loss
- How much weight loss? _____

HEAD/EYES/EARS

- YES NO Hair Loss
- YES NO Pain in Eye
- YES NO Eye Injury
- YES NO Double Vision
- YES NO Blurry/Decreased Vision
- YES NO Difficulty Hearing
- YES NO Ear Aches
- YES NO Buzzing or ringing in Ears
- YES NO Sensation of spinning

NOSE/THROAT/NECK

- YES NO Recurrent sore throats
- YES NO Persistent Hoarseness
- YES NO Frequent Nosebleeds
- YES NO Mouth Ulcers
- YES NO Oral Bleeding
- YES NO Dental Problems
- YES NO Sinus Trouble
- Swollen lymph nodes or glands
Where _____
- YES NO Difficulty Swallowing
- YES NO Masses or Lumps
- YES NO Dry Mouth
- YES NO Altered Taste
- YES NO Neck Pain

SKIN

- YES NO Chronic skin condition
- YES NO Lump or Growth on skin
- YES NO Change in color of skin
- YES NO Easy bruising
- YES NO Skin Tumors or moles
- YES NO Rash

BREASTS

- YES NO Masses or Lumps
- YES NO Nipple Discharge
- YES NO Nipple Inversion
- YES NO Pain

HEART

- YES NO Chest pain
- YES NO Ankle swelling
- YES NO Sleeping with head elevated
- YES NO Fainting
- YES NO Calf cramps with walking
- YES NO Pacemaker

LUNG

- YES NO Cough
- YES NO Shortness of Breath
- YES NO Blood in sputum
- YES NO Wheezing/Asthma
- YES NO Tuberculosis or Exposure
- YES NO Infections/Pneumonia
- YES NO Chest pain

GASTROINTESTINAL

- YES NO Frequent heartburn/indigestion
- YES NO Nausea or Vomiting
- YES NO Abdominal Pain
- YES NO Diarrhea or Frequent Stools
- YES NO Blood in Stool
- YES NO Blood in Vomit
- YES NO Trouble Swallowing
- YES NO Yellow Skin/Jaundice
- YES NO Constipation
- YES NO Decreased Appetite
- YES NO Change in stools
- YES NO Black, tarry stools
- YES NO Hemorrhoids

BONES AND MUSCLES

- YES NO Painful Joints
- YES NO Sore Muscles
- YES NO Bone Pain
- YES NO Muscle Weakness
- YES NO Decreased range of motion

ENDOCRINE

- YES NO Hot Flashes
- YES NO Other endocrine diseases

HEMATOLOGIC/LYMPH

- YES NO Bruising
- YES NO Enlarges lymph nodes



Tallahassee Memorial Cancer Center

Tallahassee Memorial HealthCare

GENITOURINARY

Decrease size/force of urine stream YES NO
 Increased frequency of urination YES NO
 How Often? _____
 Burning sensation during urination YES NO
 Nighttime urination YES NO
 How many times at night? _____
 Sensation that bladder cannot empty YES NO
 Blood in urine YES NO
 Incontinence YES NO
 Erectile dysfunction (men only) YES NO

PSYCHIATRIC

Delusions/Hallucinations YES NO
 Mood Swings YES NO
 Depression YES NO
 OTHER YES NO

NEURO

Frequent or severe headaches YES NO
 Dizziness or faintness YES NO
 Nervousness/Anxiety YES NO
 Numbness/tingling YES NO
 Memory Loss YES NO
 Seizures YES NO
 Disorientation YES NO
 Weakness YES NO
 Abnormal gait YES NO

WOMEN ONLY

Age at first menstruation: _____ Date of last period: _____ Last Pap: _____
 Number of Pregnancies: _____ Number of Live Births: _____
 Age of children: _____
 Vaginal Discharge or bleeding YES NO
 Irregular periods YES NO
 Painful Intercourse YES NO
 Ever use hormones YES NO
 Gone through menopause YES NO If "yes" when: _____
 Date & location of mammogram showing cancer: _____
 Date & location of last normal mammogram: _____

PATIENT PHYSICIANS INFORMATION

Who referred you to our office? _____
 Primary Care Physician _____
 General Surgeon _____
 Oncology Physician(Chemo) _____
 Pulmonary Physician(Lung) _____
 Neurology/Neurosurgery Physician(Brain) _____
 Dermatology Physician(Skin) _____
 Urology Physician(Bladder/Prostate) _____

List all upcoming Physician Appointments: _____

Do you have a Living will? YES NO
 If no, would you like information about how to establish a Living Will? YES NO

Do you have a Health Care Surrogate? YES NO
 If yes, please provide the person/s name and phone number: _____

SCREENING TOOLS FOR MEASURING DISTRESS

Date: _____

Patient Name: _____

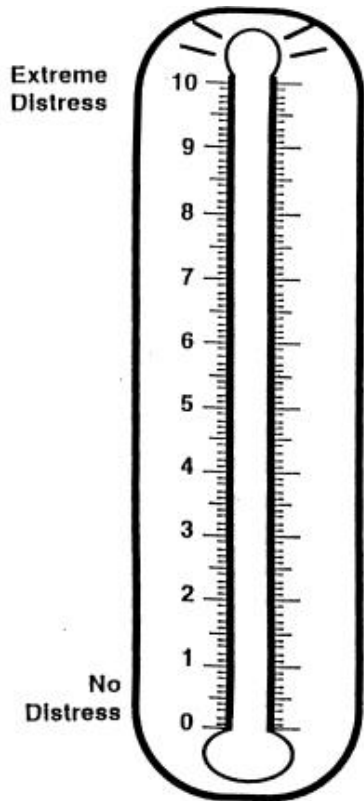
Patient's Date of Birth: _____

Patient's Signature: _____

TMH Colleague: _____

First, please circle the number (0-10) that best describes how much distress you have been experiencing in the past week, including today.

Secondly, please indicate if any of the following has been a problem for you in the past week, including today. Be sure to check YES or no FOR each.



YES	NO	<u>PRACTICAL PROBLEMS</u>	YES	NO	<u>PHYSICAL PROBLEMS</u>
<input type="checkbox"/>	<input type="checkbox"/>	Child care	<input type="checkbox"/>	<input type="checkbox"/>	Appearance
<input type="checkbox"/>	<input type="checkbox"/>	Housing	<input type="checkbox"/>	<input type="checkbox"/>	Bathing/dressing
<input type="checkbox"/>	<input type="checkbox"/>	Insurance/financial	<input type="checkbox"/>	<input type="checkbox"/>	Breathing
<input type="checkbox"/>	<input type="checkbox"/>	Transportation	<input type="checkbox"/>	<input type="checkbox"/>	Changes in urination
<input type="checkbox"/>	<input type="checkbox"/>	Work/school	<input type="checkbox"/>	<input type="checkbox"/>	Constipation
			<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea
			<input type="checkbox"/>	<input type="checkbox"/>	Eating
<input type="checkbox"/>	<input type="checkbox"/>	<u>FAMILY PROBLEMS</u>	<input type="checkbox"/>	<input type="checkbox"/>	Fatigue
<input type="checkbox"/>	<input type="checkbox"/>	Dealing with children	<input type="checkbox"/>	<input type="checkbox"/>	Feeling swollen
<input type="checkbox"/>	<input type="checkbox"/>	Dealing with partner	<input type="checkbox"/>	<input type="checkbox"/>	Fevers
<input type="checkbox"/>	<input type="checkbox"/>	Ability to have children	<input type="checkbox"/>	<input type="checkbox"/>	Getting around
			<input type="checkbox"/>	<input type="checkbox"/>	Indigestion
			<input type="checkbox"/>	<input type="checkbox"/>	Memory/concentration
<input type="checkbox"/>	<input type="checkbox"/>	<u>EMOTIONAL PROBLEMS</u>	<input type="checkbox"/>	<input type="checkbox"/>	Mouth sores
<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	Nausea
<input type="checkbox"/>	<input type="checkbox"/>	Fears	<input type="checkbox"/>	<input type="checkbox"/>	Nose dry/congested
<input type="checkbox"/>	<input type="checkbox"/>	Nervousness	<input type="checkbox"/>	<input type="checkbox"/>	Pain
<input type="checkbox"/>	<input type="checkbox"/>	Sadness	<input type="checkbox"/>	<input type="checkbox"/>	Sexual
<input type="checkbox"/>	<input type="checkbox"/>	Worry	<input type="checkbox"/>	<input type="checkbox"/>	Skin dry/itchy
<input type="checkbox"/>	<input type="checkbox"/>	Loss of interest in usual activities	<input type="checkbox"/>	<input type="checkbox"/>	Sleep
<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	Tingling in hands/feet
<input type="checkbox"/>	<input type="checkbox"/>	<u>SPIRITUAL/RELIGIOUS CONCERNS</u>	<input type="checkbox"/>	<input type="checkbox"/>	

Other problems/comments _____

FAX TO: 431-1687



AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient's Name: _____
Last First Middle (Maiden)

Patient's Date of Birth: _____ **SSN:** _____ **Phone:** _____

PERSON OR ENTITY TO DISCLOSE (RELEASE) INFORMATION:

PERSON OR ENTITY TO USE (RECEIVE) INFORMATION:

Name (Releaser)

Name (Releasee)

Address

Address

City State Zip

City State Zip

SPECIFIC INFORMATION TO BE DISCLOSED (Check the appropriate box as needed):

- Discharge Summary Only Emergency Room Record Billing Record
- Clinical Abstract (History & Physical, Discharge Summary, Operative Report, Pathology Report, X-Ray Reports)
- Other: _____

Dates of service: _____

For the purpose of: Further Care Insurance Legal Personal Use Other

This authorization will expire on: _____ If no date is specified, it will expire ninety (90) days after the date it is signed.

I DO **I DO NOT** authorize the release of information pertaining to specific laboratory tests of **HIV infection** (Human Immunodeficiency Virus, the causative agent of AIDS), the results of such tests, the diagnosis of **Acquired Immune Deficiency Syndrome (AIDS)** or **AIDS related conditions**, and all medical records and clinical information relating thereto. **Initials of individual giving authorization:** _____

I DO **I DO NOT** authorize the release of all information, including but not limited to the medical/clinical record and other information pertaining to any evaluation, treatment and/or hospitalization for **mental health** or **psychiatric** conditions. **Initials of individual giving authorization:** _____

I DO **I DO NOT** authorize the release of all information, including but not limited to the medical/clinical record and other information relating to any evaluation, treatment and/or hospitalization for **drug or alcohol abuse, drug-related and/or alcohol-related** treatment. **Initials of individual giving authorization:** _____

When my health information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. The use or disclosure of the information identified above is voluntary and I need not sign this form to ensure healthcare treatment. I have read and understand the nature of this authorization and understand that it may be revoked upon my written request to the TMH Privacy Officer, except to the extent that action has already been taken on this authorization. Releaser and its agents and employees are hereby authorized to obtain, inspect, and reproduce such records and/or information and are hereby relieved of any responsibility or liability that may arise from the release or reproduction of such records and/or information.

Signature of Patient Or Patient's Representative

Witness

Relationship to Patient (if applicable, attach document of guardianship or Power of Attorney)

Date

Date



**Tallahassee Memorial
Hospital**

Tallahassee Memorial HealthCare

Place Label Here

CONDITIONS OF ADMISSION 2014

1. Release of Information

I do hereby authorize TMH and any physician examining and/or treating me to release to any third party payor, any medical, psychiatric or psychological and/or alcohol or drug abuse, AIDS, ARC or HIV information and records concerning diagnosis and treatment either during inpatient or outpatient treatment for use in connection with determining a claim for payment for such treatment and/or diagnosis. **The Hospital is authorized to release information from my medical record to any skilled nursing facility or other healthcare provider to which I may be transferred.** I also understand information regarding HIV, tuberculosis, viral meningitis, and other diseases may be required to be reported to health departments or the Centers for Disease Control and Prevention.

2. Assignment of Benefits

In consideration of hospital and medical services rendered or to be rendered to this patient, I hereby assign to Tallahassee Memorial Hospital and all treating physicians and groups, all my rights, title and interest in benefits due from any and all insurance policies and/or benefit programs. **I authorize payment to be made directly to the Hospital and all treating physicians and groups of any and all sums of money otherwise payable to me under the terms of said insurance policies and/or benefit programs, but not to exceed the regular and customary charges for the services rendered.** In the event this payment is insufficient to meet total Hospital or professional charges, **I understand I am financially responsible and obligated to pay the provider for all charges not covered by this assignment and the Hospital has the right to demand payment in full from me at any time prior to payment from any source.** I authorize TMH to obtain a credit report.

3. Notice to Medicare Patients

Please be advised that personal convenience items are not covered by Medicare. *You will be billed for*

any such items. Also, we need to inform you that there are certain drugs that Medicare will not pay for during your Hospital treatment. Medicare has already provided this information to you in your Medicare update. According to Medicare regulations and regardless of your condition or who administered the drug, **any tablet, capsule, suspension (including eye drops), ointment, patch or suppository, will not be paid by Medicare in an outpatient setting,** regardless of the fact that your doctor ordered the drug and that you received it. Tallahassee Memorial Hospital realizes the financial burden this Medicare policy may place upon you, but we must abide by their rules. If you are unable to pay this bill and feel that you qualify for charity, please contact Patient Financial Services at (850) 431-6200. **My initials signify that I have received "An important message from Medicare".**

Initial _____

4. Personal Valuables

I understand that the Hospital maintains a safe for the safekeeping of money and valuables, and **the Hospital shall not be liable for the loss or damage to any money, jewelry, documents, dentures, eye glasses, hearing aids, fur coats and fur garments or other articles of unusual value and small size, unless placed therein, and shall not be liable for loss or damage to any other personal property unless deposited with the Hospital for safekeeping.**

5. Weapons/Explosive/Drugs

I understand and agree that if the Hospital at any time believes there may be a weapon, explosive devices, illegal substance or drug, or any alcoholic beverage in my room or with my belongings, the Hospital may search my room and my belongings, confiscate any of the above items that are found, and dispose of them as appropriate, including delivery of any item to law enforcement authorities.

Please Initial Here _____

6. Guarantee of Account

I, the undersigned, agree, whether I sign as parent, guardian, spouse, agent, guarantor, or as patient, that in consideration of the services to be rendered to the patient, I hereby individually obligate myself to pay the account of the Hospital in accordance with the regular rates and terms of the Hospital. Should the account be referred to an attorney or collection agency for collection, I shall pay actual attorney's fees and collection expenses.

7. Billing

It is very important that you know who will be billing you for services. You will receive a bill from Tallahassee Memorial. You will also receive a bill from physicians who provided your care. These physicians will include, but not limited to, your surgeon, anesthesiologist, radiologist, ER physician, hospitalist, or any other specialist who participates in your care. Although the physicians are on the medical staff, most physicians are not affiliated with the hospital. Therefore, they will send you a separate

bill. If you have any questions, please call TMH's Business Office at (850) 431-6200.

8. Pathology Services

You may receive services from pathologists as a patient at the hospital. The pathologist is responsible for analysis of specimens and assuring that the results of your tests are clinically valid, reliable, and reported in a timely manner to your doctor. You will receive a separate bill from the pathologist for the professional component of anatomic and clinical pathology services performed on your behalf. You agree to pay the pathologist for those services unless the pathologist has entered into an agreement with your insurance company to accept payment in full or unless otherwise provided by law.

9. Privacy Notification

My signature below indicates that I have received Tallahassee Memorial HealthCare's Notice of Privacy Practices.

I hereby certify and state that I have read, and that I fully and completely understand this Conditions of Admission, and that I have signed this Conditions of Admission knowingly, freely, and voluntarily. Moreover, I certify and state that I have received no promises, assurances, or guarantees from anyone as to the results that may be obtained by any medical treatment or services.

My signature below indicates that I understand that this form and my signature will be kept on file for the 2014 calendar year.

PATIENT / LEGAL REPRESENTATIVE

WITNESS (to signature only)

RELATIONSHIP TO PATIENT

DATE

DATE

1. General Consent to Treat

I, the undersigned, consent to the procedures which may be performed during this hospitalization or on an outpatient basis, including emergency treatment or services, and which may include but are not limited to laboratory procedures, x-ray examination, diagnostic procedures, anesthesia, or hospital services rendered to me under the general and special instructions of my physician. The undersigned recognizes that all physicians furnishing services to the patient are independent practitioners and are not employees or agents of the hospital. This includes, but is not limited to, physicians such as radiologists, anesthesiologists and their physician extenders.

This consent may include testing for blood-borne infectious diseases, including but not limited to hepatitis. Acquired Immuno Deficiency Syndrome (AIDS), and Human Immuno-deficiency Virus (HIV), if a physician orders such test(s) for diagnostic purposes.

The County Health Department, Florida Department of Health may access communicable disease information upon presentation of proper identification or call back verification from the patients' medical record to enforce provision of reportable diseases detailed in Florida Administrative Code (F.A.C.) Chapter 64D-3.

This consent also authorizes Hospital staff for continuum of care to photograph any skin breakdown that may be present upon admission or may develop during this admission.

2. Consent to Photograph

I hereby consent to allow physicians and staff at Tallahassee Memorial Hospital to take photographs to be used in connection with my diagnosis, care and treatment. I understand I may withdraw my consent at any time, and that my medical care is not dependent upon my agreement to have photographs taken.

3. Patient Self-Determination Act

I acknowledge that I have been given information regarding Florida's Living Wills and Advance Directive. Advance Directives are documents such as Living Wills, Durable Powers of Attorney, or Health Care Surrogate Appointments.

- _____ I have received information

A. Please Initial the following applicable statement:

- _____ I have executed an Advance Directive and have been requested to supply a copy to the hospital.*
- _____ I have not executed an Advance Directive and do not want one at this time.

* Please complete reverse side regarding intent and Surrogate/Decision Maker.

I hereby certify and state that I have read, and that I fully and completely understand this Consent for Treatment, and that I have signed this Consent for Treatment knowingly, freely, and voluntarily. Moreover, I certify and state that I have received no promises, assurances, or guarantees from anyone as to the results that may be obtained by any medical treatment or services.

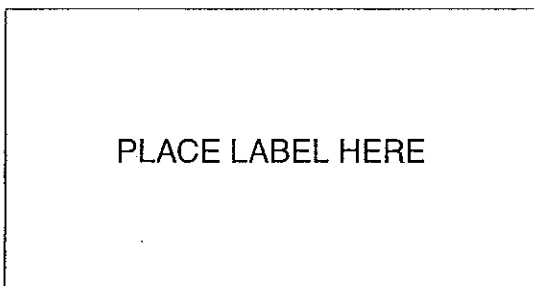
PATIENT/PARENT/SPOUSE/LEGAL REPRESENTATIVE

WITNESS (to signature only)

RELATIONSHIP TO PATIENT

DATE / TIME

DATE / TIME



**Tallahassee Memorial
Hospital**

Tallahassee Memorial HealthCare

CONSENT FOR TREATMENT

ADVANCE DIRECTIVES INTENT

You have indicated you have an Advance Directive, but do not have it with you. We need your help in answering the questions below so that we can understand your desires under your Advance Directive and can meet your health care needs.

- > Pain medication to keep me comfortable. Yes ___ No ___
- > Resuscitation if my heart or breathing stops Yes ___ No ___
- > Food and water through tubes in my veins, nose or stomach Yes ___ No ___
- > Kidney dialysis, if my kidneys fail. Yes ___ No ___
- > Mechanical breathing, if I am unable to breath on my own Yes ___ No ___
- > Life prolonging measures Yes ___ No ___
- > Prolong life regardless of pain and chances of recovery Yes ___ No ___
- > Organ donor Yes ___ No ___

Health Care Surrogate / Decision Maker

In the event I am determined to be incapacitated to provide informed consent for hospital treatment and surgical and diagnostic procedures, I wish to designate the person(s) listed below as my health care surrogate(s) to make my health care decisions.

Name

Phone Address

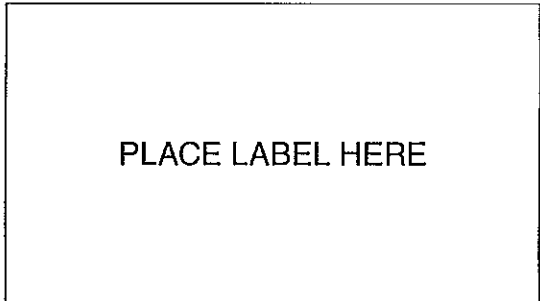
• _____ I do not wish to name a surrogate at this time.

Patient's Signature

Date / Time

Print Patient's Name

This information would be used only in the event you become unresponsive or incapacitated or your health care surrogate is unavailable



NOTICE OF PRIVACY PRACTICES OF: Tallahassee Memorial Hospital and Tallahassee Memorial HealthCare, Inc.

Effective Date: April 14, 2003 Revised Date: September 13, 2013

This notice describes the privacy practices of all inpatient and outpatient departments and units of Tallahassee Memorial Hospital and all facilities operated by Tallahassee Memorial HealthCare, Inc. with the exception of Tallahassee Memorial Behavioral Health Center.

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

A. PURPOSE OF THE NOTICE OF PRIVACY PRACTICES

A record is made of the care and services you receive each time you are a patient in our hospital or one of our affiliated facilities. This record documents such things as your physical examination, test results, diagnosis, treatment, plans for future care, and information related to billing. We need this record to provide you with quality care and to comply with certain legal requirements. This notice describes the type of information we gather about you while you are a patient, with whom that information may be shared and the safeguards we have in place to protect it. It applies to all records of your care generated by hospital personnel, agents of the hospital, or your doctor. Please note that your doctor may provide you with a notice regarding the use and disclosure of your health information in his particular office.

B. OUR LEGAL DUTY REGARDING YOUR MEDICAL INFORMATION

We are required by law to keep private any medical information that identifies you and provide you with a description of our privacy practices with respect to your medical information. We will follow applicable laws and the terms of the notice that are currently in effect.

C. HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

1. Permitted and Required Uses and Disclosures of Your Health Information Which DO NOT Require Your Written Authorization or the Opportunity for You to Object or Agree

The following categories describe the different ways that we may use and disclose medical information and examples of each. Not every possible use or disclosure in a category will be listed.

For Treatment: We may use health information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, training doctors, or other health care professionals who are involved in taking care of you. 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. Different healthcare professionals also may share health information about you in order to coordinate the different things you may need, such as medications, lab work, meals, and x-rays. We may also disclose medical information about you to people outside the facility who may be involved in your medical care after you are discharged or that provide services that are part of your continuing care.

For Payment: We may use and disclose health information about your treatment and services to bill and collect payment from you, your insurance company or a third party payer. For example, we may need to give your insurance company information about your treatment so they will pay us or reimburse you. We may also use and disclose medical information about you to obtain prior approval or determine whether your insurance plan will cover the treatment. We may contact you for the purpose of billing/collection efforts. This may include leaving a message on your answering machine/voice mail.

For Health Care Operations: Members of our medical staff, clinical departments, and administrative units may use information in your medical record to review the care and outcomes in your case and similar cases. This is necessary to continually improve the quality of care for all patients we serve. For example, we may disclose information to doctors, nurses, technicians, training doctors, medical students, and other facility personnel for review and learning purposes. We may combine medical information about many patients to assess the need for new services or treatment. This information may be combined with that of other facilities for the purposes of studying health care delivery. We may remove information that identifies you from this set of medical information to protect your privacy. We may also use and disclose health information to assess your satisfaction with our services and for reviewing the competence of health care professionals.

Business Associates: Certain services are provided in our organization through contracts with business associates. We may disclose your health information to our business associates so that they can perform the job we've asked them to do. Some examples include CPA firms whose accounting services involve access to protected health information, healthcare clearinghouses that transmit claims on our behalf, independent medical transcriptionists who type medical reports, or a copy service we use to make copies of your health record. To protect your privacy, we require each business associate to sign an agreement that obligates the business associate to use appropriate safeguards to protect your health information.

Funeral Directors and Medical Examiners: Consistent with applicable law, we may use and disclose your health information to funeral directors and medical examiners in the event of your death.

Research: We may disclose information to researchers when an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information has approved their research and granted a waiver of the authorization requirement.

Future Communications: We may communicate to you via newsletters, mailings or other means regarding treatment options, health related information, disease-management programs, wellness programs, or other community based initiatives or activities in which our facilities are participating.

As Required by Law: We will disclose medical information about you when required to do so by federal, state or local law. This may include, but is not limited to requests from the following types of entities: 1) Food and Drug Administration; 2) Public Health or Legal Authorities charged with preventing or controlling disease, injury or disability; 3) Governmental Authority which by law receives the reports of child abuse and neglect; 4) Protective Services for Victims of Abuse, Neglect or Domestic Violence; 5) Correctional Institutions; 6) Workers Compensation Agents; 7) Organ and Tissue Donation Organizations; 8) Military Command Authorities; 9) Health Oversight Agencies; 10) National Security and Intelligence Agencies; 11) Protective Services for the President and Others.

Law Enforcement/Legal Proceedings: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Appointment Reminders: We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or medical care. This may include leaving a message on your answering machine/voice mail.

Fundraising Activities: We may use health information about you in an effort to raise money for Tallahassee Memorial HealthCare, Inc. and its operations. We may disclose certain information to the TMH Foundation so that the Foundation may raise money for the hospital. You have the right to request (opt-out) that we not contact you for fund raising efforts. **If you do not want to be contacted for fundraising efforts, you must notify us as directed by the fundraising communication (correspondence) or notify our Privacy Officer by phone or in writing at the number or address on the last page.**

Affiliated Covered Entities: Protected health information will be made available to personnel at all facilities affiliated with and managed by Tallahassee Memorial HealthCare as necessary to carry out treatment, payment, and health care operations. Caregivers at other facilities may have access to protected health information at their locations to assist in reviewing past treatment information as it may affect treatment at this time. **Please contact the TMH Privacy Officer for further information on the specific sites which are affiliated with TMH.**

Organized Health Care Arrangement: Our facilities and their medical staff members share an organized health care arrangement. Information will be shared as necessary to carry out treatment, payment, and health care operations. Physicians and caregivers may have access to protected health information in their offices to assist in reviewing past treatment as it may affect treatment at the time.

2. Uses and Disclosures of Your Health Information Which DO Require That You Have the Opportunity to Object or Agree

We may disclose the following kinds of health information about you, if you are informed in advance of the use and disclosure, and you have had the opportunity to agree to or prohibit or restrict the use and disclosure of this information. We may inform you verbally or in writing of these types of uses and disclosures, and you may agree or object verbally or in writing to these uses and disclosures.

Directory: We may include certain limited information about you in our facility directory while you are a patient here. This information may include your name and location, (whether an inpatient, outpatient, or Emergency Center patient.) It may also include your general condition (e.g. fair, stable, etc.) and your religious affiliation. This information may be provided to members of the clergy and, except for religious affiliation, to other people who ask for you by name. If you do not want to be included in the directory, please advise the Registration staff and request the "Opt Out Form".

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

3. Uses and Disclosures of Your Health Information Which Require Your Authorization

The following uses and disclosures will be made only with your written permission: 1) Most uses and disclosures of psychotherapy notes; 2) Disclosures that constitute the sale of your protected health information; 3) Uses and disclosures for marketing purposes.

D. YOUR RIGHTS REGARDING YOUR MEDICAL INFORMATION

Your medical record is the physical property of the healthcare practitioner or facility that compiled it; however you have the right to:

Inspect and Copy: You have the right to inspect and obtain a copy of the health information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes. **To inspect and obtain a copy your medical information, you must submit your request in writing to our Privacy Officer or our Director, Medical Records at the address at the end of this notice.**

If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy in certain circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional selected by Tallahassee Memorial HealthCare will review your request and the denial. We will comply with the outcome of the review.

Amend: If you feel that the medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the facility. **To request an amendment, your request must be made in writing and submitted to our Privacy Officer.** In addition, you must provide a reason that supports your request. We may deny your request for an amendment and if this occurs, you will be notified of the reason for the denial.

An Accounting of Disclosures: You have the right to request an accounting of disclosures. This is a list of certain disclosures we make of your health information for purposes other than treatment, payment or health care operations where an authorization was not required. **To request an accounting of disclosures, you must submit your request in writing to our Privacy Officer.**

Request Restrictions: You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had. With the exception of "Out-of-Pocket Payments," described below, we are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

To request restrictions, you must make your request in writing to our Privacy Officer. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply. Restrictions may be terminated upon your

oral or written agreement, your written request or upon you receiving a notice from us that we are terminating the agreement to a restriction.

To request restrictions regarding your presence and/or location in the facility, you must make this known when you register or check-in as a patient.

Out-of-Pocket Payments: If you prefer that we not bill your health plan for a specific item or service and you have timely paid out-of-pocket in full for that specific item or service, then you have the right to ask that your protected health information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request. Your request to limit disclosure in this way must be submitted in writing.

Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you may ask that we contact you at work instead of your home. The facility will grant reasonable requests for confidential communications at alternative locations and/or via alternative means **only if the request is submitted in writing to our Privacy Officer.** We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted.

Notification of a Breach: You have the right to be notified of any breach of your unsecured protected health information.

A Paper Copy of This Notice: You have the right to a paper copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our website, www.tmh.org. **To obtain a paper copy of this notice, please request one when you register or check-in as a patient or contact our Privacy Officer.**

E. OTHER USES OF MEDICAL INFORMATION WHICH REQUIRE YOUR WRITTEN AUTHORIZATION

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

F. CHANGES TO THIS NOTICE

We reserve the right to change this notice and the revised or changed notice will be effective for information we already have about you as well as any information we receive in the future. The current notice will be posted in the facility and include the effective date. You have the right to obtain a copy of the revised notice upon request.

G. COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the TMH Privacy Officer at the address below or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

H. TALLAHASSEE MEMORIAL HEALTHCARE PRIVACY OFFICER

You may contact the TMH Privacy Officer at 850-431-5339. Written requests or inquiries may be sent to:

Privacy Officer (OR) Director, Medical Records (for record copy request)
Tallahassee Memorial HealthCare, Inc.
1300 Miccosukee Road
Tallahassee, FL 32308

Secretary of the Department of Health and Human Services
Region IV-Office of Civil Rights
U.S. Department of Health and Human Services
Atlanta Federal Center, Suite 3B70
61 Forsyth Street, SW
Atlanta, GA 30303-8980
Phone: 404-562-7886 Fax: 404-562-7881
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