Admissions Staff

Place Patient ID Sticker Here

Patient Registration

Please read and complete both sides of this form

Date:_____ Time:_____

Legal first and last name of person being assessed today: _____

Date of Birth:_____ Age: _____ Sex:_____ Race:_____

Marital Status:_____ Social Security #: _____

County: _____ Phone #: _____

Address:_____City:_____

State: _____Zip:_____Employer: _____

Emergency Contact _____ Relationship:_____ Phone #_____

Address:_____

How did you hear about Holly Hill Hospital?_____

What type of treatment are you seeking today? _____

Have you been a patient at Holly Hill in the past? _____ How long ago?_____

Guarantor/Guardian Name: _____ Relationship: _____
❑ Check if information is the same as patient Guarantor/Guardian Phone Number:_____
Guarantor/Guardian Address: _____

Insurance Information

Primary Insurance:_____

Name of policyholder:_____ Policy #:_____

Group#:_____ SS# of policyholder:_____

Date of Birth:_____ Employer:_____

Secondary Insurance:_____

Name of policyholder:_____ Policy #:_____

Continued on Back

Please Provide us with Information on Your Network of Support:

Please list your treatment providers below. (Circle the appropriate credentials for each provider.)

PROVIDER 1: Psychiatrist/Psychologist/Therapist/SW:_____
City_____ State_____ Phone#:_____

When was the last time you saw this provider? (circle one)
1-3 months **3-6 months** **6+ months**

PROVIDER 2: Psychiatrist/Psychologist/Therapist/SW_____
City_____ State_____ Phone#:_____

When was the last time you saw this provider? (circle one)
1-3 months **3-6 months** **6+ months**

PROVIDER 3: Psychiatrist/Psychologist/Therapist/SW:_____
City_____ State_____ Phone#:_____

When was the last time you saw this provider? (circle one)
1-3 months **3-6 months** **6+ months**

If Child/Adolescent List School Name _____

Would you like information provided to your provider network? ❑ *Yes* ❑ *No*

STAFF USE ONLY

Release of Information Signed during admission for ALL providers:
❑ Yes ❑ No, patient declined ❑ No providers

Outpatient Providers contacted by Intake staff during admission process via:
❑ Direct call ❑ Voice mail ❑ Unable to reach or leave voicemail ❑ Patient declined ❑ No providers

Staff Signature:_____ Date/Time:_____

Notes:_____

Respecting Your Privacy

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.

PROTECTED HEALTH INFORMATION

Information about your health is private. And it should remain private. That is why this healthcare institution is required by federal and state law to protect and maintain the privacy of your health information. We call it "Protected Health Information" (PHI).

The basis for federal privacy protection is the Health Insurance Portability and Accountability Act (HIPAA) and its regulations, known as the "Privacy Rule" and "Security Rule" and other federal and state privacy laws.

WHO WILL FOLLOW THIS NOTICE

This Notice describes the information privacy practices followed by our hospital employees, volunteers, and related personnel.

The practices described in this Notice may also be followed by health care providers, who are members of our Medical Staff, if they have opted to abide by its contents. Many of our doctors follow the practices contained within this Notice.

Each participant who joins in this joint Notice of Privacy Practices serves as their own agent for all aspects of HIPAA Compliance, other than the delivery of this Joint Notice. For physician specific issues or questions, please feel free to contact your physician directly.

Hospital employees, volunteers, and related personnel, including those members of the Medical Staff who have opted to abide by its contents, must follow this Notice with respect to:

- How We Use Your PHI
- Disclosing Your PHI to Others
- Your Privacy Rights
- Our Privacy Duties
- Hospital Contacts for More Information or, if necessary, a Complaint

USING OR DISCLOSING YOUR PHI:

FOR TREATMENT

During the course of your treatment, we use and disclose your PHI. For example, if we test your blood in our laboratory, a technician will share the report with your doctor. Or, we will use your PHI to follow the doctor's orders for an x-ray, surgical procedure or other types of treatment related procedures.

FOR PAYMENT

After providing treatment, we will ask your insurer to pay us. Some of your PHI may be entered into our computers in order to send a claim to your insurer. This may include a description of your health problem, the treatment we provided and your membership number in your employer's health plan.

Or, your insurer may want to review your medical record to determine whether your care was necessary. Also, we may disclose to a collection agency some of your PHI for collecting a bill that you have not paid.

FOR HEALTHCARE OPERATIONS

Your medical record and PHI could be used in periodic assessments by physicians about the hospital's quality of care. Or we might use the PHI from real patients in education sessions with medical students training in our hospital. Other uses of your PHI may include business planning for our hospital or the resolution of a complaint.

SPECIAL USES

Your relationship to us as a patient might require using or disclosing your PHI in order to

- Remind you of an appointment for treatment
- Tell you about treatment alternatives and options
- Tell you about our other health benefits and services

YOUR AUTHORIZATION MAY BE REQUIRED

In many cases, we may use or disclose your PHI, as summarized above, for treatment, payment or healthcare operations or as required or permitted by law. In other cases, we must ask for your written authorization with specific instructions and limits on our use or disclosure of your PHI. This includes, for example, uses or disclosures of psychotherapy notes, uses or disclosures for marketing purposes, or for any disclosure which is a sale of your PHI. You may revoke your authorization if you change your mind later.

CERTAIN USES AND DISCLOSURES OF YOUR PHI REQUIRED OR PERMITTED BY LAW

As a hospital or healthcare facility, we must abide by many laws and regulations that either require us or permit us to use or disclose your PHI.

REQUIRED OR PERMITTED USES AND DISCLOSURES

- Your information may be included in a patient directory that is available only to those individuals whom you have identified as contacts during your hospital stay. You will receive a unique patient code that can be provided to these contacts
- If you do not verbally object, we may share some of your PHI with a family member or friend involved in your care.
- We may use your PHI in an emergency when you are not able to express yourself.
- We may use or disclose your PHI for research if we receive certain assurances which protect your privacy.

WE MAY ALSO USE OR DISCLOSE YOUR PHI

- When required by law, for example when ordered by a court.
- For public health activities including reporting a communicable disease or adverse drug reaction to the Food and Drug Administration.
- To report neglect, abuse or domestic violence.
- To government regulators or agents to determine compliance with applicable rules and regulations.
- In judicial or administrative proceedings as in response to a valid subpoena.
- To a coroner for purposes of identifying a deceased person or determining cause of death, or to a funeral director for making funeral arrangements.
- For purposes of research when a research oversight committee, called an institutional review board, has determined that there is a minimal risk to the privacy of your PHI.
- For creating special types of health information that eliminate all legally required identifying information or information that would directly identify the subject of the information.
- In accordance with the legal requirements of a Workers' Compensation program.
- When properly requested by law enforcement officials, for instance in reporting gun shot wounds, reporting a suspicious death or for other legal requirements.
- If we reasonably believe that use or disclosure will avert a health hazard or to respond to a threat to public safety including an imminent crime against another person.
- For national security purposes including to the Secret Service or if you are Armed Forces personnel and it is deemed necessary by appropriate military command authorities.
- In connection with certain types of organ donor programs.

YOUR PRIVACY RIGHTS AND HOW TO EXERCISE THEM

Under the federally required privacy program, patients have specific rights.

YOUR RIGHT TO REQUEST LIMITED USE OR DISCLOSURE

You have the right to request that we do not use or disclose your PHI in a particular way. We must abide by your request to restrict disclosures to your health plan (insurer) if:

- the disclosure is for the purpose of carrying out payment or health care operations and is not required by law; and
- the PHI pertains solely to a healthcare item or service that you, or someone else other than the health plan (insurer) has paid us for in full.

In other situations, we are not required to abide by your request. If we do agree to your request, we must abide by the agreement.

YOUR RIGHT TO CONFIDENTIAL COMMUNICATION

You have the right to receive confidential communications of PHI from the hospital at a location that you provide. Your request must be in writing, provide us with the other address and explain if the request will interfere with your method of payment.

YOUR RIGHT TO REVOKE YOUR AUTHORIZATION

You may revoke, in writing, the authorization you granted us for use or disclosure of your PHI. However, if we have relied on your consent or authorization, we may use or disclose your PHI up to the time you revoke your consent.

YOUR RIGHT TO INSPECT AND COPY

You have the right to inspect and copy your PHI (or to an electronic copy if the PHI is in an electronic medical record), if requested in writing. We may refuse to give you access to your PHI if we think it may cause you harm, but we must explain why and provide you with someone to contact for a review of our refusal.

YOUR RIGHT TO AMEND YOUR PHI

If you disagree with your PHI within our records, you have the right to request, in writing, that we amend your PHI when it is a record that we created or have maintained for us. We may refuse to make the amendment and you have a right to disagree in writing. If we still disagree, we may prepare a counter-statement. Your statement and our counter-statement must be made part of our record about you.

YOUR RIGHT TO KNOW WHO ELSE SEES YOUR PHI

You have the right to request an accounting of certain disclosures we have made of your PHI over the past six years, but not before April 14, 2003. We are not required to account for all disclosures, including those made to you, authorized by you or those involving treatment, payment and health care operations as described above. There is no charge for an annual accounting, but there may be charges for additional accountings. We will inform you if there is a charge and you have the right to withdraw your request, or pay to proceed.

YOUR RIGHT TO BE NOTIFIED OF A BREACH

You have the right to be notified following a breach of unsecured PHI.

YOUR RIGHT TO OBTAIN A PAPER COPY OF THIS NOTICE

You have the right to obtain a paper copy of this notice upon request, even if you have agreed to receive the Notice electronically.

WHAT IF I HAVE A COMPLAINT?

If you believe that your privacy has been violated, you may file a complaint with us or with the Secretary of Health and Human Services in Washington, D.C. We will not retaliate or penalize you for filing a complaint with us or the Secretary.

- To file a complaint with us, please contact our Risk Management Department or call the UHS Compliance Hotline at **1-800-852-3449**. Your complaint should provide specific details to help us in investigating a potential problem.
- To file a complaint with the Secretary of Health and Human Services, write to: 200 Independence Ave., S.E., Washington, D.C.20201 or call **1-877-696-6775.**

CONTACT FOR ADDITIONAL INFORMATION

If you have questions about this Notice or need additional information, you can contact our Risk Management Department (or the UHS Compliance Hotline at 1-800-852-3449).

SOME OF OUR PRIVACY OBLIGATIONS AND HOW WE FULFILL THEM

Federal health information privacy rules require us to give you notice of our legal duties and privacy practices with respect to PHI and to notify you following a breach of unsecured PHI. This document is our notice. We will abide by the privacy practices set forth in this notice. We are required to abide by the terms of the notice currently in effect. However, we reserve the right to change this notice and our privacy practices when permitted or as required by law. If we change our notice of privacy practices, we will provide you with a copy to take with you upon request and we will post the new notice.

COMPLIANCE WITH CERTAIN STATE LAWS

When we use or disclose your PHI as described in this notice, or when you exercise certain of your rights set forth in this notice, we may apply state laws about the confidentiality of health information in place of federal privacy regulations. We do this when these state laws provide you with greater rights or protection for your PHI. For example, some state laws dealing with mental health records may require your express consent before your PHI could be disclosed in response to a subpoena. Another state law prohibits us from disclosing a copy of your record to you until you have been discharged from our hospital. When state laws are not in conflict or if these laws do not offer you better rights or more protection, we will continue to protect your privacy by applying the federal regulations.

Effective Date: This notice takes effect on September 23, 2013 Version # 1

Signing below only acknowledges receipt of Holly Hill Hospital's Notice of Privacy Practices.

_____

Name of Patient (Print or Type)

_____ _____ _____

Signature of Patient Date Time

_____ _____ _____

Signature of Authorized Personal Representative Date Relationship

_____ _____

Signature of Witness – HHH Employee Date /Time

Holly Hill Hospital

Consent to Use and Disclose Protected Health Information

Use and Disclosure of Your Protected Health Information

Your protected health information will be used by Holly Hill Hospital or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of the hospital.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for more complete description of how your protected health information may be used or disclosed. You may review the notice prior to signing this consent.

Requesting a Restriction on the Use or Disclosure of Your Information

You may request a restriction on the use or disclosure of your protected health information.
Holly Hill Hospital may or may not agree to restrict the use or disclosure of your protected health information.

If **Holly Hill Hospital** agrees to your request, the restriction will be binding on the facility. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Reservation of Right to Change Privacy Practices

Holly Hill Hospital reserves the right to modify the privacy practices outlined in the notice.

Signature of Patient or Authorized Personal Representative

I have reviewed this consent form and give my permission to **Holly Hill Hospital** to use and disclose my health information in accordance with it.

_____
Name of Patient (Print or Type)

_____ ___ _____
Signature of Patient Date

_____ ___ _____
Signature of Authorized Personal Representative/Parent/Legal Guardian

Relationship of Authorized Personal Representative to Patient

_____ _____
Signature of Witness – HHH Employee Date /Time

Form #098001 Rev. 9/15

HH 2075 92015REV

HOLLY HILL HOSPITAL
FINANCIAL AGREEMENT

The undersigned hereby agree as follows:

1) **GUARANTEE OF PAYMENT:** Holly Hill Hospital (HHH) and the Physician/Healthcare Professional identified above has been or will be providing care to the patient whose name appears above. I hereby agree to guarantee the payment of the bill for services rendered by HHH and the Physician/Healthcare Professional. I agree whether signing as guarantor or as patient, that in consideration of the services to be rendered to the patient, to be hereby jointly and individually obligated to pay the account of HHH and the Physician/Healthcare Professional in accordance with the regular rates and terms of HHH and the Physician/Healthcare Professional. Should the account be referred for collection by an attorney or collection agency, I agree to pay all attorney fees and other reasonable collection costs and charges that are necessary for the collection of any amount(s) not paid when due.
2) **ASSIGNMENT OF INSURANCE BENEFITS:** In consideration of medical services rendered or to be rendered by HHH and the Physician/Healthcare Professional, to the extent permitted by law, I hereby (I) irrevocably assign, transfer, and set over to HHH and the Physician/Healthcare Professional (II) all of my rights, title and interest to medical reimbursement, including, but not limited to, (III) the right to designate a beneficiary, add dependent eligibility and (IV) to have an individual policy continued or issued in accordance with the terms and benefits under any insurance policy, subscription certificate or other health indemnification agreement otherwise payable to me for those services rendered by HHH and the Physician/Healthcare Professional during the pendency of the claim for this admission. Such irrevocable assignment and transfer shall be for the recovery on said policy(ies) of insurance, but shall not be construed to be an obligation of HHH and the Physician/Healthcare Professional to pursue any such right of recovery. I hereby authorize the insurance company(ies) or third party payer(s) providing coverage for services to pay directly to HHH and the Physician/Healthcare Professional all benefits due for service rendered.
3) **Authorization to Use and Disclose Protected Health Information for Payment Purposes:** I hereby authorize the use or disclosure of the information identified herein, which may include information regarding drug/alcohol abuse, treatment and rehabilitation, psychological or psychiatric impairments, physical conditions, HIV, and/or AIDS, and other communicable diseases by HHH for payment purposes. The information to be used or disclosed includes those records which are necessary to support claims for payment or reimbursement for services provided to Patient. I understand that I may revoke or terminate this authorization at any time by submitting a written revocation to the HHH Privacy Official, except to the extent that action has already been taken in reliance thereon. If not previously revoked, this authorization will automatically expire six months following discharge. I hereby acknowledge that this consent is voluntary and that there are statutes and regulations protecting the confidentiality of authorized information.
4) **INSUFFICIENT INSURANCE COVERAGE:** If any insurance or other third party coverage which the patient may have rejects the patient's claim or pays only part of the claim, the undersigned shall be responsible for payment of the balance due, as determined by HHH and the Physician/Healthcare Professional.
5) I acknowledge that this agreement has been read and is understood. I further acknowledge an understanding that the physician's charges will be billed separately from or in addition to charges that may be billed by HHH or other licensed Healthcare professionals who may provide services to the patient.

FOR MINORS OR OTHER DEPENDENTS COVERED UNDER PARENTAL GROUP HEALTH PLANS

For married parents of patient, please supply the following information: Mothers DOB_____

Fathers DOB_____

For separated or divorced parents of patient, the separation agreement or divorce decree places legal custody with:

_____

I CERTIFY THAT THE INFORMATION SUBMITTED ON THIS FORM IS CORRECT TO THE BEST OF MY KNOWLEDGE AND I AGREE TO ALL OF THE PROVISIONS SET FORTH IN THIS FINANCIAL AGREEMENT.

_____	_____	_____
Patient Name – Please Print	Date	Signature of Patient (Over 18 years old)

_____	_____	_____
Parent/ Legal Representative/Guarantor – Please Print	Date	Signature of Parent/Legal Representative/Guarantor

_____	_____
Signature of Witness – HHH Employee	Date/Time

Form # HH9061 9/2015REV