Saint Francis Hospital - Memphis
Center for Surgical Weight Loss

Robert W. Wegner, MD, Medical Director
Vanessa D. Williams, FNP-BC

Saint Francis Center for Surgical Weight Loss
6005 Park Avenue Ste. 1010 B, Memphis Tn. 38119

*****PLEASE NOTE This is our office, not our seminar address. Please see directions to our seminar location at the bottom of this page (in red)*****

Phone: (901) 881-0600
Fax: (901) 765-3049

Thank you for contacting the Saint Francis Center for Surgical Weight Loss.

Please follow the instructions provided in order to process your application.

- Complete the attached Program Application in its entirety.
- A copy of the front and back of your insurance card(s) is required in order to process your application.
- Bring the completed Program Application and copy of your insurance card(s) to the Bariatric Seminar you have been scheduled to attend.

If you have questions, please call our office at (901) 881-0600 and ask to speak to one of the Patient Advocates.

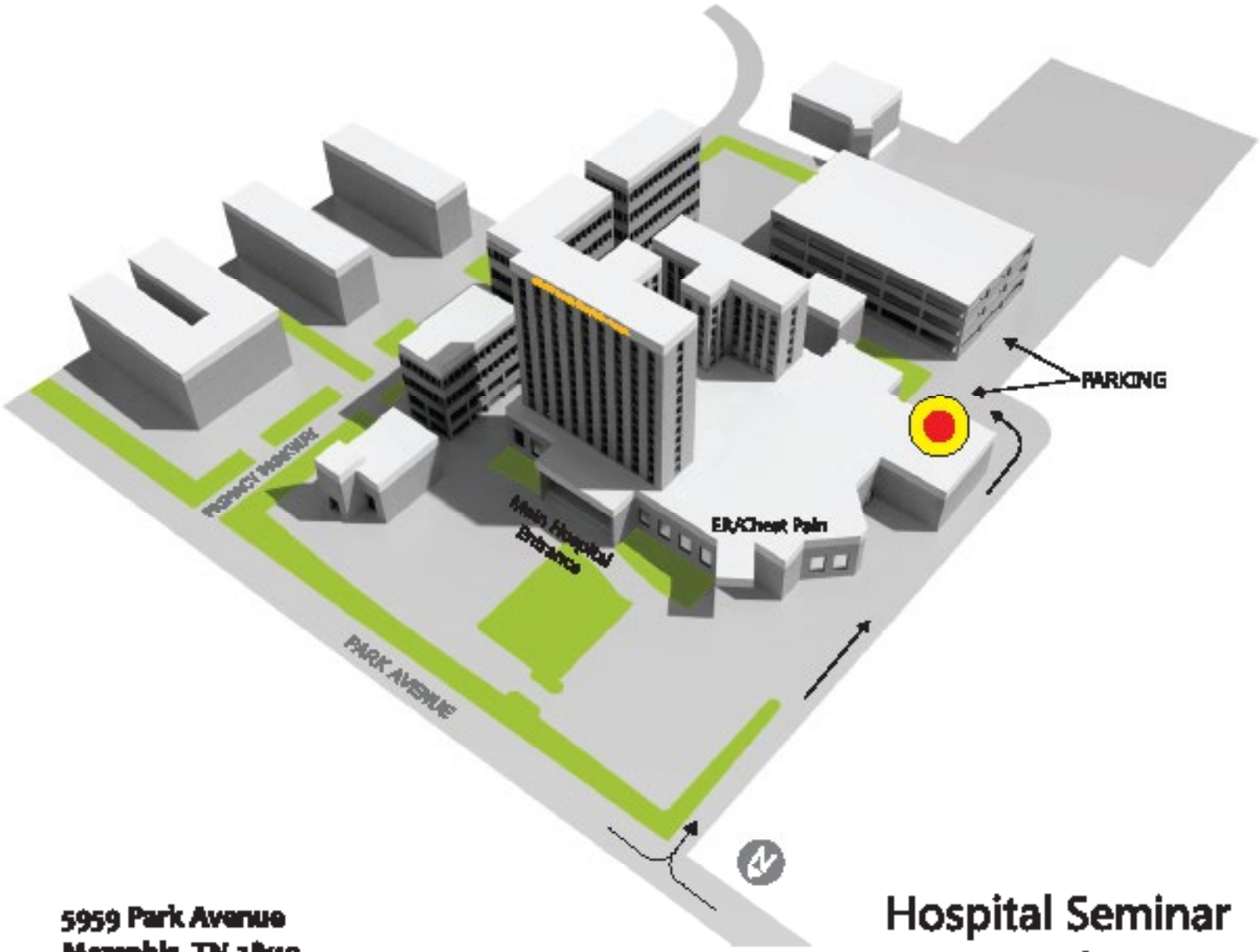
Directions To Our Seminar

Saint Francis Hospital
5959 Park Avenue
Memphis, Tn. 38119.

From Park Avenue, take the driveway leading to the Emergency Room. Continue around to the back (Nurses Row) and park in the small parking lot. Look for the door to the auditorium; this is where you will enter. The room is the second door on the right.

"We can change the way you see yourself"
www.memphisweightlosssurgery.com

Saint Francis Hospital - Memphis



5959 Park Avenue
Memphis, TN 38119
901-765-1811

Saint Francis Hospital-Memphis is located at the southwest corner of Park Avenue and Primacy Parkway.

Hospital Seminar Location

ST. CATHERINE HALL

Come in the Longinotti Auditorium Entrance

Saint Francis Hospital - Memphis
Center for Surgical Weight Loss

Seminar Type: ☐ ONLINE ☐ IN-PERSON
Seminar Date: _____

Patient Information

PATIENT'S LAST NAME, FIRST, MIDDLE		RACE	☐ MALE ☐ FEMALE	AGE	DATE OF BIRTH
STREET ADDRESS	CITY		STATE		ZIP CODE
SOCIAL SECURITY #	HOME / CELL PHONE	WORK PHONE	MARITAL STATUS ☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ WIDOWED		
PATIENT'S OCCUPATION		EMPLOYER'S NAME			

***Primary Care Physician**	**How did you hear about us?**

***** Email Address:**

RESPONSIBLE PARTY INFORMATION				
LAST NAME, FIRST, MIDDLE			SOCIAL SECURITY #	DATE OF BIRTH
RELATIONSHIP TO PATIENT	STREET ADDRESS	CITY	STATE	ZIP CODE
HOME PHONE	WORK PHONE	EMPLOYER		

INSURANCE INFORMATION - A COPY OF YOUR INSURANCE CARD(S) - FRONT AND BACK - IS REQUIRED				
INSURANCE CO NAME	POLICY NO	GROUP NO	PHONE NUMBER	POLICY HOLDER & DOB
INSURANCE CO NAME	POLICY NO	GROUP NO	PHONE NUMBER	POLICY HOLDER & DOB
INSURANCE CO NAME	POLICY NO	GROUP NO	PHONE NUMBER	POLICY HOLDER & DOB

IN CASE OF EMERGENCY NOTIFY (OTHER THAN RESPONSIBLE PARTY)	
NAME (ADDRESS IF POSSIBLE)	PHONE

I AUTHORIZE THE RELEASE AND DISCLOSURE OF ANY OR MY ENTIRE MEDICAL AND TREATMENT RECORDS OR REPORTS TO ANY OTHER HEALTH CARE PROVIDER WHO MAY BE OF ASSISTANCE, IN THE OPINION OF SAINT FRANCIS CENTER FOR SURGICAL WEIGHT LOSS, AND/OR FOR ASSISTING IN ANY REIMBURSEMENT OR MEDICAL BENEFITS TO WHICH PATIENT MAY BE ENTITLED. I ALLOW FAX TRANSMITTAL OF MY MEDICAL RECORDS, IF NECESSARY. I FURTHER AUTHORIZE AND REQUEST THAT INSURANCE PAYMENTS BE MADE DIRECTLY TO SAINT FRANCIS CENTER FOR SURGICAL WEIGHT LOSS SHOULD THEY ELECT TO RECEIVE SUCH PAYMENT. **THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.** A PHOTOCOPY OF THIS ASSIGNMENT SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.

I ACKNOWLEDGE FULL FINANCIAL RESPONSIBILITY FOR SERVICES RENDERED BY SAINT FRANCIS CENTER FOR SURGICAL WEIGHT LOSS. I UNDERSTAND THAT PAYMENT OF CHARGES INCURRED IS DUE AT THE TIME OF SERVICE UNLESS OTHER DEFINITE FINANCIAL ARRANGEMENTS HAVE BEEN MADE PRIOR TO TREATMENT. I AGREE TO PAY ALL REASONABLE ATTORNEY FEES AND COLLECTION COSTS IN THE EVENT OF A DEFAULT OF PAYMENT OF MY CHARGES.

I AUTHORIZE TREATMENT BY SAINT FRANCIS CENTER FOR SURGICAL WEIGHT LOSS PHYSICIANS AND PERSONNEL.

I HAVE READ AND FULLY UNDERSTAND THE ABOVE CONSENT FOR TREATMENT, FINANCIAL RESPONSIBILITY, RELEASE OF MEDICAL INFORMATION AND INSURANCE AUTHORIZATION. THIS AUTHORIZATION IS VALID FOR ONE YEAR.

PATIENT'S SIGNATURE _____ GUARDIAN SIGNATURE (IF MINOR) _____ DATE _____ Revised 9 27 2011

Name: _____ **DOB:** _____

Previous Hospitalizations/Surgeries/Serious Illnesses **Date**

_____ _____

_____ _____

_____ _____

Have you had a previous weight loss surgery? _____

Any Problem with Anesthesia (if so, what problem): _____

_____

Have you or any of your family members had any type of problem with anesthesia? _____

_____

Patient Social History

Marital Status Single:____ Married:____ Separated:____ Divorced:____ Widowed:____

Patient Lives Alone:____ With Family:____ Other:____

Use of Alcohol Never:____ Rarely:____ Moderate:____ Daily:____

Use of tobacco Never:____ Previously, but quit:____ Current packs per day:____

Use of Drugs Never:____ Type/Frequency:_____

Adaptive Self-Care Aids: None____ Cane____ Walker____ Wheelchair____ Oxygen____ Other:_____

Family Support:

How does your support person (family) feel about you having this type of surgery?

_____

_____

Biopsychosocial:

Religion:_____

Religious needs we may help you with during your hospital stay: **Y** **N**

Explain:_____

Cultural: Any cultural practice we should be aware of to assist us in providing care: **Y** **N**

Explain:_____

Highest Education level/degree earned:_____

Family medical history: (parents, grandparents, brothers, sisters) Please indicate who has or has had these health problems:

Obesity:_____

Lung Disease, Asthma or Emphysema:_____

Diabetes:_____

Kidney Disease:_____

High Blood Pressure:_____

Bleeding Tendency or Blood Disorder:_____

Heart Disease (Indicate what type):_____

Breast Cancer:_____

High Blood Cholesterol:_____

Colon Cancer:_____

Liver Problems:_____

Weight History:

Current Height: _____Ft. _____ In.

Current Weight:_____ Pounds

What was your approximate weight for each of the past five years?

Year	Weight	Year	Weight
20 _____	_____	20 _____	_____
20 _____	_____	20 _____	_____
20 _____	_____		

Please list all diets. diet pills and diet programs that you have attempted:_____

_____

_____

Name: _____ **DOB:** _____

Review of Symptoms: Please indicate any personal history below:

Genitourinary ☐ None

___ Frequent Urination
___ Kidney Stones
___ Bladder Stones
___ Kidney Failure
___ Nephritis
___ Urinary Tract Infections
Last UTI: _____
___ Incontinence or Dribbling
___ Pain with Urination
___ Leakage of urine with coughing laughing or sneezing
___ On Dialysis
Comments:
_____
_____

Psychological ☐ None

___ Nervousness
___ Anxiety
___ Depression
Medication: _____
___ Hospitalization for emotional problem. When/Where?
_____
_____
Name of Dr. treating/has treated you
_____
Is he/she aware that you are interested
in having bariatric surgery? _____
Comments: _____
_____

Neurological ☐ None

___ Stroke
___ Sleeping Difficulty (what kind?)
_____
___ Dizziness, vertigo
___ Numbness, tingling feelings, weakness. Where? _____
___ Tremors
___ Convulsions / Seizures
When and what caused it?_____
_____
___ Loss of consciousness (when & why?) _____
___ Pseudotumor Cerebri
Comments: _____

Respiratory ☐ None

___ Cough / wheezing
___ Shortness of breath
__ frequent __on exertion
If you walk at a fairly good pace how far can you walk before being out of breath? _____
Ever hospitalized for asthma? ___
_____
On Oxygen? _____
___ Pulmonary embolus
(blood clot in lung)
___ COPD
___ Emphysema
___ Bronchitis: When _____
___ Sleep Apnea __CPAP __BIPAP
__Snore __Stop Breathing
When and where was the sleep study done? _____
_____
Comments:_____
_____

Cardiovascular ☐ None

___ Angina
___ Palpitations
___ Can you lie flat on your back?
If no, what happens when you lie down?
_____
___ Pain in neck, chest, arms
___ Heart attack
___ Abnormal Electrocardiogram
___ Irregular Heartbeat
___ High blood Pressure
How long _____
Medication _____
___ Congestive heart failure
___ High cholesterol / tryglicerides
How long? _____
___ Blood clots in legs
___ Recent ECG
___ Pacemaker
___ Heart Cath
Comments: _____
_____

Gastrointestinal ☐ None

___ Indigestion
___ Nausea/Vomiting
___ Diarrhea
___ Constipation
___ GERD
___ Pain with bowel movement
___ Blood in stools
___ Hemorrhoids
___ Irritable colon
___ Colitis
___ Gallbladder Disease
___ Gallbladder Removal
___ Recent colonoscopy
___ Recent EGD or "Scope"
___ Ulcers
___ History of H.pylori
___ Liver Problems
___ Hepatitis
Comments: _____
_____
_____

Endocrine ☐ None

___ Thyroid Disease
When diagnosed _____
Medication: _____
___ Diabetes
__ Insulin / __ Oral Agent
Date of onset
___ Diabetic Diet Instruction
Calorie Level: _____
___ Adrenal Gland Tumor
Comments:_____
_____
_____

Musculoskeletal ☐ None

___ Pain/Swelling in Joints
___ Degenerative Joint Disease
___ Arthritis
___ Low back pain / back injury
___ Ankle and foot pain
___ Joint Replacements
Which Ones? _____
___ Ankle and foot pain
___ Fibromyalgia
___ Multiple Sclerosis
Comments:_____
_____

Other Conditions ☐ None

___ HIV / AIDS
___ Bleeding disorder
___ Blood clotting disorder
Other Conditions we shoudl be aware of?
_____
_____
_____
_____
_____
_____
_____
_____

Name: _____ **DOB:** _____

Allergies to Medications: _____

_____

Allergies to Food: _____

Latex or Other Allergies: _____

MEDICATION LOG

Date RX	Medication	Dosage	Frequency

☐ Medication List Added Separately

Are you on any blood thinners or steroids e.g. Prednisone? _____

Your pharmacy's name and phone number: _____

What are your expectations of bariatic surgery?_____

_____

_____

_____

How much weight do you expect to lose?_____

Which procedure do you prefer:

Roux-en-Y Gastric Bypass: _____ Sleeve Gastrectomy: _____

Laparoscopic Adjustable Banding: _____ Converting From Band: _____

Saint Francis Hospital - Memphis

Center for Surgical Weight Loss

MEDICAL INFORMATION COMMUNICATION CONSENT

Patient Name: _____ Date of Birth: _____

Doctor Name: _____

In compliance with federal law, it is the policy of Saint Francis Center for Surgical Weight Loss to **NOT** release confidential, personal, and/or unauthorized information by home telephone, answering machine, work telephone, voice mail, cellular telephone, pager and/or fax unless authorized below. We will not leave a message on an answering machine where the recorded message does not identify the name or number called. Information will not be left with an unauthorized person who may answer your telephone.

_____ I authorize SF Center for Surgical Weight Loss to leave medical information pertaining to my care by the following methods and will assume responsibility to notify SF Center for Surgical Weight Loss whenever this information changes.

- ☐ answering machine/voice mail #s: _____
- ☐ email: _____
- ☐ with the following people listed:

_____ Relationship: _____

_____ Relationship: _____

_____ Relationship: _____

_____ I do not give SF Center for Surgical Weight Loss permission to leave medical information with any person other than myself.

Patient Signature: _____ Date: _____

Witness Signature: _____ Expiration: _____

SFMP
SAINT FRANCIS MEDICAL PARTNERS

Saint Francis Hospital - Memphis

Center for Surgical Weight Loss

FINANCIAL POLICY

We hope to make your visits in our office as thorough and pleasant as possible. We also want you to have a full understanding of our financial policies and expectations for payment for services. Please carefully review and sign our financial policy, and let us know of any questions you may have.

The primary and final relationship is between the physician(s) (Saint Francis Medical Partners) and you (the patient), and our contract is with you. We will not compromise your medical care to satisfy **ANY** insurance company. Bear in mind, insurance is meant to help defray the cost of medical care and is **NOT** intended to dictate your treatment. If you have any questions regarding your treatment or plan of care, do not hesitate to ask your provider. Services performed are at your consent, and proper payment is required.

Payment is due and expected in full at the time services are rendered unless other arrangements are made PRIOR to your appointment. This includes deductibles, co-payments, co-insurances and non-covered services.

As a courtesy, we are happy to assist you in the filing of most insurance claims, completing insurance forms, and insurance pre-certification. You will be responsible for any and all balances not covered by your insurance. If your insurance has not paid their portion within 60 days of being properly billed, the entire balance will be your responsibility. The **ULTIMATE RESPONSIBILITY** for the filing and processing of claims to satisfy your insurance carrier **REMAINS WITH YOU**. If you are unsure of any specific requirements of your insurance, **PLEASE ASK THEM**. We are unable to be completely familiar with every type of insurance and plan. As the insured client, you are in the best position to follow up and exert pressure on your insurance carrier to ensure payment is being processed.

You will receive a monthly statement requesting payment of any unpaid balance. If your account becomes past due, please contact our billing office to discuss payment arrangements and avoid further collection efforts. We are committed to being sensitive to patient financial difficulties, but we are unable to assist if you do not contact us to discuss your account.

There is a fee for any checks returned by the bank. Patient balances that go unpaid for 90 days or more will incur additional interest charges of 1% per month or 12% APR. Appointments not cancelled with 24 hour notice may result in charges for time reserved.

We are here to serve your health needs and will work hard on your behalf, to contain fees and other charges while providing you with quality health care.

I have read and understand the above policies. I understand that I may receive a copy of this form upon request.

_____ **X**_____

Print Patient Name / Social Security Number | Signature of Patient or Responsible Party

_____ _____

Witness | Date

SFMP
SAINT FRANCIS MEDICAL PARTNERS

Saint Francis Hospital - Memphis

Center for Surgical Weight Loss

NOTICE OF PRIVACY PRACTICES (NPP) ACKNOWLEDGEMENT

A **Notice of Privacy Practices (NPP)** is provided to all patients. This Notice of Privacy Practices identifies: 1) how medical information about you may be used or disclosed; 2) your rights to access your medical information, amend your medical information, request an accounting of disclosures of your medical information and request additional restrictions on our uses and disclosures of that information; 3) your rights to complain if you believe your privacy rights have been violated; and 4) our responsibilities for maintaining the privacy of your medical information.

The undersigned certifies that he/she has read the foregoing, received a copy of the Notice of Privacy Practices and is the patient, or the patient's personal representative.

PATIENT'S PRINTED NAME _____ DATE OF BIRTH _____

PATIENT'S SIGNATURE _____ DATE _____

PATIENT/LEGAL REPRESENTATIVE SIGNATURE _____ RELATIONSHIP TO PATIENT _____

WITNESS (FOR INTERNAL USE ONLY) _____ DATE _____

The following names are of people I would like to be involved in or have access to my protected health information on a routine basis. I give permission for Saint Francis Medical Partners to share my protected health information with:

NAME _____ RELATIONSHIP _____

NAME _____ RELATIONSHIP _____

NAME _____ RELATIONSHIP _____

SFMP SAINT FRANCIS MEDICAL PARTNERS

NOTICE OF PRIVACY PRACTICES

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

Who Presents this Notice

This Notice describes the privacy practices of ***Saint Francis Center for Surgical Weight Loss (Saint Francis Medical Partners)*** and members of its workforce, as well as the physician members of the medical staff and allied health professionals who practice at the Practice. The Practice and the individual health care providers together are sometimes called "the Practice and Health Professionals" in this Notice. While the Practice and Health Professionals engage in many joint activities and provide services in a clinically integrated care setting, the Practice and Health Professionals each are separate legal entities. This Notice applies to services furnished to you at the Practice as a Practice patient or any other services provided to you in a Practice-affiliated program involving the use or disclosure of your health information.

Privacy Obligations

The Practice and Health Professionals each are required by law to maintain the privacy of your health information ("Protected Health Information" or "PHI") and to provide you with this Notice of legal duties and privacy practices with respect to your Protected Health Information. The Practice and Health Professionals use computerized systems that may subject your Protected Health Information to electronic disclosure for purposes of treatment, payment and/or health care operations as described below. When the Practice and Health Professionals use or disclose your Protected Health Information, the Practice and Health Professionals are required to abide by the terms of this Notice (or other notice in effect at the time of the use or disclosure).

Permissible Uses and Disclosures Without Your Written Authorization

In certain situations your written authorization must be obtained in order to use and/or disclose your PHI. However, the Practice and Health Professionals do not need any type of authorization from you for the following uses and disclosures:

Uses and Disclosures for Treatment, Payment and Health Care Operations. Your PHI, may be used and disclosed to treat you, obtain payment for services provided to you and conduct "health care operations" as detailed below:

- Treatment. Your PHI may be used and disclosed to provide treatment and other services to you--for example, to diagnose and treat your injury or illness. In addition, you may be contacted to provide you appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. Your PHI may also be disclosed to other providers involved in your treatment. For example, a doctor treating you for a broken leg may need to know if you have diabetes because if you do, this may impact your recovery.

- Payment. Your PHI may be used and disclosed to obtain payment for services provided to you--for example, disclosures to claim and obtain payment from your health insurer, HMO, or other company that arranges or pays the cost of some or all of your health care ("Your Payor") to verify that Your Payor will pay for health care. The physician who reads your x-ray may need to bill you or your Payor for reading of your x-ray therefore your billing information may be shared with the physician who read your x-ray.

- Health Care Operations. Your PHI may be used and disclosed for health care operations, which include

internal administration and planning and various activities that improve the quality and cost effectiveness of the care delivered to you. For example, PHI may be used to evaluate the quality and competence of physicians, nurses and other health care workers. PHI may be disclosed to the Practice Compliance & Privacy Office in order to resolve any complaints you may have and ensure that you have a comfortable visit. Your PHI may be provided to various governmental or accreditation entities such as the Joint Commission on Accreditation of Healthcare Organizations to maintain our license and accreditation. In addition, PHI may be shared with business associates who perform treatment, payment and health care operations services on behalf of the Practice and Health Professionals.

Use or Disclosure for Directory of Individuals in the Practice. The Practice may include your name, location in the Practice, general health condition and religious affiliation in a patient directory without obtaining your authorization *unless* you object to inclusion in the directory. Information in the directory may be disclosed to anyone who asks for you by name. Your religious affiliation may be given to a member of the clergy, such as a priest or minister, even if they do not ask for you by name. If you do not wish to be included in the facility directory, you will be given an opportunity to object at the time of admission.

Disclosure to Relatives, Close Friends and Other Caregivers. Your PHI may be disclosed to a family member, other relative, a close personal friend or any other person identified by you who is involved in your health care or helps pay for your care. If you are not present, or the opportunity to agree or object to a use or disclosure cannot practicably be provided because of your incapacity or an emergency circumstance, the Practice and/or Health Professionals may exercise professional judgment to determine whether a disclosure is in your best interests. If information is disclosed to a family member, other relative or a close personal friend, the Practice and/or Health Professionals would disclose only information believed to be directly relevant to the person's involvement with your health care or payment related to your health care. Your PHI also may be disclosed in order to notify (or assist in notifying) such persons of your location or general condition.

Public Health Activities. Your PHI may be disclosed for the following public health activities: (1) to report health information to public health authorities for the purpose of preventing or controlling disease, injury or disability; (2) to report child abuse and neglect to public health authorities or other government authorities authorized by law to receive such reports; (3) to report information about products and services under the jurisdiction of the U.S. Food and Drug Administration; (4) to alert a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition; and (5) to report information to your employer as required under laws addressing work-related illnesses and injuries or workplace medical surveillance.

Victims of Abuse, Neglect or Domestic Violence. Your PHI may be disclosed to a governmental authority, including a social service or protective services agency, authorized by law to receive reports of such abuse, neglect, or domestic violence if there is a reasonable belief that you are a victim of abuse, neglect or domestic violence.

Health Oversight Activities. Your PHI may be disclosed to a health oversight agency that oversees the health care system and is charged with responsibility for ensuring compliance with the rules of government health programs such as Medicare or Medicaid.

Judicial and Administrative Proceedings. Your PHI may be disclosed in the course of a judicial or administrative proceeding in response to a legal order or other lawful process.

Law Enforcement Officials. Your PHI may be disclosed to the police or other law enforcement officials as required or permitted by law or in compliance with a court order or a grand jury or administrative subpoena. For example, your PHI may be disclosed to identify or locate a suspect, fugitive, material witness, or missing person or to report a crime or criminal conduct at the facility.

Correctional Institution. You PHI may be disclosed to a correctional institution if you are an inmate in a correctional institution and if the correctional institution or law enforcement authority makes certain requests to us.

Business Associates. Your PHI may be disclosed to business associates or third parties that the Practice and Health Professionals have contracted with to perform agreed upon services.

Decedents. Your PHI may be disclosed to a coroner or medical examiner as authorized by law.

Organ and Tissue Procurement. Your PHI may be disclosed to organizations that facilitate organ, eye or tissue procurement, banking or transplantation.

Research. Your PHI may be used or disclosed without your consent or authorization if an Institutional Review Board approves a waiver of authorization for disclosure.

Health or Safety. Your PHI may be used or disclosed to prevent or lessen a serious and imminent threat to a person's or the public's health or safety.

Specialized Government Functions. Your PHI may be disclosed to units of the government with special functions, such as the U.S. military, the U.S. Department of State under certain circumstances such as the Secret Service or NSA to protect, for example, the country or the President.

Workers' Compensation. Your PHI may be disclosed as authorized by and to the extent necessary to comply with state law relating to workers' compensation or other similar programs.

As Required by Law. Your PHI may be used and disclosed when required to do so by any other law not already referred to in the preceding categories; such as required by the FDA, to monitor the safety of a medical device.

Appointment Reminders. Your PHI may be used to tell or remind you about appointments.

Fundraising. Your PHI may be used to contact you as a part of fundraising efforts, unless you elect not to receive this type of information.

USES AND DISCLOSURES REQUIRING YOUR WRITTEN AUTHORIZATION

Use or Disclosure with Your Authorization. For any purpose other than the ones described above, your PHI may be used or disclosed only when you provide your written authorization on an authorization form ("Your Authorization"). For instance, you will need to execute an authorization form before your PHI can be sent to your life insurance company or to the attorney representing the other party in litigation in which you are involved.

Marketing. Your written authorization ("Your Marketing Authorization") also must be obtained prior to using your PHI to send you any marketing materials. (However, marketing materials can be provided to you in a face-to-face encounter without obtaining Your Marketing Authorization. The Practice and/or Health Professionals are also permitted to give you a promotional gift of nominal value, if they so choose, without obtaining Your Marketing Authorization). The Practice and/or Health Professionals may communicate with you in a face-to-face encounter about products or services relating to your treatment, case management or care coordination, or alternative treatments, therapies, providers or care settings without Your Marketing Authorization.

In addition, the Practice and/or Health Professionals may send you treatment communications, unless you elect not to receive this type of communication, for which the Practice and/or Health Professionals may receive financial remuneration.

Sale of PHI. The Practice and Health Professionals will not disclose your PHI without your authorization in exchange for direct or indirect payment except in limited circumstances permitted by law. These circumstances include public health activities; research; treatment of the individual; sale, transfer, merger or consolidation of the Practice; services provided by a business associate, pursuant to a business associate agreement; providing an individual with a copy of their PHI; and other purposes deemed necessary and appropriate by the U.S. Department of Health and Human Services (HHS).

Uses and Disclosures of Your Highly Confidential Information. In addition, federal and state law require special privacy protections for certain highly confidential information about you ("Highly Confidential Information"), including the subset of your PHI that: (1) is maintained in psychotherapy notes; (2) is about mental illness, mental retardation and developmental disabilities; (3) is about alcohol or drug abuse or addiction; (4) is about HIV/AIDS testing, diagnosis or treatment; (5) is about communicable disease(s), including venereal disease(s); (6) is about genetic testing; (7) is about child abuse and neglect; (8) is about domestic abuse of an adult; or (9) is about sexual assault. In order for your Highly Confidential Information to be disclosed for a purpose other than those permitted by law, your written authorization is required.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

Right to Request Additional Restrictions. You may request restrictions on the use and disclosure of your PHI (1) for treatment, payment and health care operations, (2) to individuals (such as a family member, other relative, close personal friend or any other person identified by you) involved with your care or with payment related to your care, or (3) to notify or assist in the notification of such individuals regarding your location and general condition. While all requests for additional restrictions will be carefully considered, the Practice and Health Professionals are not required to agree to these requested restrictions.

You may also request to restrict disclosures of your PHI to your health plan for payment and healthcare operations purposes (and not for treatment) if the disclosure pertains to a healthcare item or service for which you paid out-of-pocket in full. The Practice and Health Professionals must agree to abide by the restriction to your health plan EXCEPT when the disclosure is required by law.

If you wish to request additional restrictions, please obtain a request form from the Practice and submit the completed form to the Practice. A written response will be sent to you.

Right to Receive Confidential Communications. You may request, and the Practice and Health Professionals will accommodate, any reasonable written request for you to receive your PHI by alternative means of communication or at alternative locations.

Right to Revoke Your Authorization. You may revoke Your Authorization, Your Marketing Authorization or any written authorization obtained in connection with your PHI, except to the extent that the Practice and/or Health Professionals have taken action in reliance upon it, by delivering a written revocation statement to the Practice identified below.

Right to Inspect and Copy Your Health Information. You may request access to your medical record file and billing records maintained by the Practice and Health Professionals in order to inspect and request copies of the records. Under limited circumstances, you may be denied access to a portion of your records. If you desire access to your records, please obtain a record request form from the Practice and submit the completed form to the Practice. If you request copies of paper records, you will be charged in accordance with federal and state law. To the extent the request for records includes portions of records which are not in paper form (e.g., x-ray films), you will be charge the reasonable cost of the copies. You also will be charged for the postage costs, if you request that the copies be mailed to you. However, you will not be charged for copies that are requested in order to make or complete an application for a federal or state disability benefits program.

Right to Amend Your Records. You have the right to request that PHI maintained in your medical record file or billing records be amended. If you desire to amend your records, please obtain an amendment request form from the Practice and submit the completed form to the Practice. Your request will be accommodated unless the Practice and/or Health Professionals believe that the information that would be amended is accurate and complete or other special circumstances apply.

Right to Receive an Accounting of Disclosures. Upon request, you may obtain an accounting of certain disclosures of your PHI made during any period of time prior to the date of your request provided such period does not exceed six years and does not apply to disclosures that occurred prior to April 14, 2003. If you request an accounting more than once during a twelve (12) month period, you will be charged for the accounting statement.

Right to Receive Paper Copy of this Notice. Upon request, you may obtain a paper copy of this Notice, even if you have agreed to receive such notice electronically.

For Further Information or Complaints. If you desire further information about your privacy rights, are concerned that your privacy rights have been violated or disagree with a decision made about access to your PHI, you may contact the Practice Compliance & Privacy Office. You may also file written complaints with the Director, Office for Civil Rights of the U.S. Department of Health and Human Services. Upon request, the Practice Compliance & Privacy Office will provide you with the correct address for the Director. The Practice and Health Professionals will not retaliate against you if you file a complaint with the Practice Privacy Office or the Director.

Effective Date and Duration of This Notice

Effective Date. This Notice is effective on **September 23, 2013.**

Right to Change Terms of this Notice. The terms of this Notice may be changed at any time. If this Notice is changed, the new notice terms may be made effective for all PHI that the Practice and Health Professionals maintain, including any information created or received prior to issuing the new notice. If this Notice is changed, the new notice will be posted in waiting areas around the Practice and on our Internet site at ***www.sfmp.com***. You also may obtain any new notice by contacting the Practice Compliance & Privacy Office.

PRACTICE CONTACTS:

Saint Francis Medical Partners
6005 Park Avenue, Suite 325 B
Memphis, TN 38119
Telephone Number: (901) 765-3409

Corporate Compliance & Privacy Office
Tenet Healthcare
1445 Ross Avenue, Suite 1400
Dallas, Texas 75202
E-mail: PrivacySecurityOffice@tenethealth.com
Phone: 1-877-893-8363 ext. 2009
Ethics Action Line (EAL): 1-800-8-ETHICS

Revised 11/07/14