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Welcome to Compass Medical!

We are honored you chose us as your healthcare provider! We are excited to begin our partnership with you and look forward to creating an exceptional experience for you and your family.

This **New Patient Information Packet** is designed to collect the information necessary to begin our partnership. It also contains important information for you as our patient. In an effort to streamline the registration process, please complete, sign and return the following items prior to your first appointment:

- **Patient Registration Form**
- **Payment Policy**
- **Family Health History**
- **Medication List and Preferred Pharmacy List of Current**
- **Specialists, Allergies and Surgical History**

In addition, please contact your previous Primary Care Provider to request your medical records be transferred to your new Compass Medical office. If your insurance company requires you to designate a primary care provider, please call your insurance company today to inform them of your new Compass Medical provider. Also, please remember to bring your insurance card and photo ID with you to your first appointment.

At Compass Medical, our goal is to provide exceptional medicine and compassionate care to each and every patient, every time. Our outstanding medical teams work together in Internal Medicine, Family Medicine, Urgent Care, Radiology, Cardiology, Diabetic Education, Nutrition, Podiatry, Physiatry and Behavioral Health to effectively coordinate our patients' care. Linked by our award winning, state-of-the-art electronic medical record system, Compass Medical makes it easy to visit an in-house specialist or Urgent Care provider. In addition, all Compass Medical patients have access to our in-house lab located in East Bridgewater. In addition, Compass Medical offers language assistance services, free of charge, for any patient that speaks any language other than English. Please contact your provider's office to arrange for an interpreter.

Compass Medical is an affiliate of Steward Health Care System, the largest community care organization in New England with high quality community hospitals and specialists. Our team based approach to healthcare allows us to effectively manage your health and wellness, both internally within the organization and externally with partners such as Steward Health Care System. Between in-house specialists and external partners, Compass Medical has the ability to guide patients to high quality services and meet all of your medical needs. Please discuss any specialty needs with your Provider during your visit.

Compass Medical works diligently to ensure your clinical experience is exceptional-every time. In an effort to measure your patient experience, we have teamed up with Press Ganey Associates to collect and evaluate patient feedback. After visiting with your PCP or one of our Urgent Care sites, you may receive a patient satisfaction survey in the mail or by email after your office visit. Completing these surveys provides Compass Medical with extremely important feedback and we look forward to hearing about your experience through these surveys.

Compass Medical also offers patients access to a secure and easy to use online patient portal. Compass Health Connection is a free patient portal gateway that makes it easy for you to securely access portions of your health record and allows you to navigate and make informed decisions about your health from anywhere, at any time. With Compass Health Connection, adult patients can view detailed information about your upcoming and past appointments, review your clinical visit summaries, view lab test results, view and download your Personal Health Record, request prescription refills and update personal demographic information. You can sign up for Compass Health Connection at your first appointment.

It is with the greatest pleasure that we welcome you to Compass Medical and look forward to exceeding your expectations at each and every visit. For any additional information, please visit our website at: www.CompassMedical.net.

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Account #: _____
Date: ____/____/____
PCP: _____

PATIENT REGISTRATION FORM

PERSONAL INFORMATION

First Name_____MI_____Last Name_____ Suffix_____

Previous Name_____Preferred Name_____Birth Date_____Sex ☐Female ☐ Male

Address_____City_____ State_____Zip_____Country_____

**While Compass Medical recognizes a number of genders/sexes, many insurance companies and legal entities unfortunately do not. Please be aware that the name and sex you have listed on your insurance must be used on documents pertaining to insurance, billing and correspondence.*

If a Child, Parent/Guardian's First Name_____MI_____Last Name _____

Please select a primary phone number by checking the appropriate box below

☐Home Phone (____)_____ ☐Cell Phone (____)_____ ☐Work Phone (____)_____

Marital Status ☐Married ☐Single ☐Divorced ☐Legally Separated ☐Partner ☐Widow

Email Address _____

By giving Compass Medical, P.C. my email address, I understand I am giving them permission to send me health related Information through my email with the confidence of knowing that I may safely unsubscribe at any time.

Preferred Method of Contact ☐ Letter ☐ Email

Employment Status ☐Employed ☐Retired ☐On Active Military Duty ☐Unemployed ☐Other

Student Status ☐Student ☐Not a Student

EMERGENCY CONTACT

First Name_____MI_____Last Name _____

Address_____City_____State_____Zip_____

Home Phone (____)_____Cell Phone (____)_____Work Phone (____)_____

Relationship to Patient ☐Parent ☐ Spouse ☐ Partner ☐Child ☐Sibling ☐ Grandparent ☐Other_____

INSURANCE INFORMATION

PRIMARY INSURANCE:

Insurance Company_____Phone Number (____)_____

Subscriber Name _____Relationship to Patient_____Birth Date _____

Policy #_____Group #_____Effective Date _____

SECONDARY INSURANCE:

Insurance Company_____Phone Number (____)_____

Subscriber Name _____Relationship to Patient_____Birth Date _____

Policy #_____Group #_____Effective Date _____

PHARMACY

Preferred Pharmacy Name_____Phone (____)_____

Address_____City_____State _____

HOW DID YOU HEAR ABOUT US? (Please check one.)

☐ Insurance Company ☐ Non-Compass Provider Referral ☐ Online Ad

☐ Compass Medical Website ☐ General Internet Search ☐ Other: _____

PATIENT DEMOGRAPHICS

Studies have shown there are health differences among different racial and ethnic groups. Your answers will help us make informed clinical decisions for improved delivery of your health care. Providing this information is voluntary and will be kept confidential and will only be used to meet the needs of the patients we serve.

1. Which of the following best describes your Race?

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Declined to Specify
☐ Native Hawaiian or other Pacific Islander ☐ White/Caucasian ☐ Other: _____

2. Preferred Language?

☐ English ☐ Portuguese ☐ Creole: _____ ☐ Sign Language: _____ ☐ Declined to Specify
☐ Spanish/Castilian ☐ Chinese ☐ Urdu ☐ Other: _____

3. Which of the following best describes your Ethnicity?

☐ Not Hispanic or Latino/a ☐ Hispanic or Latino/a ☐ Other: _____ ☐ Declined to Specify

STATEMENT TO PERMIT PAYMENT OF MEDICARE BENEFITS TO PROVIDER, PHYSICIANS AND PATIENT

(For Medicare Patient Use Only)

Name of Beneficiary (Patient)_____ **HICN #** (Medicare #) _____

I request that payment of authorized Medicare benefits be made either to me or on my behalf for any services furnished to me by or in Compass Medical, P.C. including physician services. I authorize any holder of medical or other information about me be released to the Centers for Medicare and Medicaid and its agents any information needed to determine these benefits or benefits for related services.

Signature of Patient:_____ **Date:** _____

RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of the Steward Health Care System Notice of Privacy Practices (included in the back of this packet) and I understand that I may request a copy of this notice at any time.

By signing my name below, I agree to the above information.

Signature of Patient or Responsible Party:_____ **Date**: _____

PRESCRIPTION HISTORY CONSENT

I authorize Compass Medical to obtain a history of my prescriptions during the course of medical care by Compass Medical Physicians and Providers.

By signing my name below, I agree to the above information.

Signature of Patient or Responsible Party:_____ **Date**: _____

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PAYMENT POLICY

Thank you for choosing us as your healthcare provider. We are committed to providing you with quality and affordable healthcare. Because some of our patients have questions regarding patient and insurance responsibility for services rendered, we have developed this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be forwarded to you upon request.

1. **INSURANCE:** We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage or prior to scheduling a physical or screening test to verify coverage for these services. It is your responsibility to verify that the physician and/or facility in which you are seeking treatment is an authorized provider under your insurance plan. A current provider listing should be made available to you by your employer, insurance company or insurance company's web-site.

2. **CO-PAYMENTS AND DEDUCTIBLES:** All co-payments must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments from patients may be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

3. **NON-COVERED SERVICES:** Please be aware that some-and perhaps all- of the services you receive may be non-covered or not considered reasonable or necessary by your insurance carrier. This may include physicals and screening tests. Please be aware that in the event of a scheduled annual physical, if the physician finds a new problem or an unstable chronic medical condition that requires further evaluation, an office visit may be billed in addition to the physical charge. However, some insurance carriers will not cover both services on the same day. Therefore, you may be billed for the portion not covered by the insurance carrier.

4. **UNINSURED:** Patients with no insurance are expected to pay for their office visit at the time of service. Any additional charges for ancillary services will be billed to the patient.

5. **PROOF OF INSURANCE:** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license or other form of valid photo identification and your current insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you will be responsible for any charges. Your insurance card must be presented at each visit.

6. **CLAIMS SUBMISSION:** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim may be your responsibility if your insurance company does not pay your claim. Your insurance benefit is a contract between you and your insurance company; we are not a party to that contract.

7. **COVERAGE CHANGES:** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. We will not be responsible for any denied claims due to filing deadlines if new insurance information was not given at the time of service.

8. **WORKERS' COMPENSATION AND AUTOMOBILE ACCIDENTS:** In the case of a workers' compensation injury or automobile accident, you must obtain the claim number, phone number, contact person, and name and address of the insurance carrier prior to your visit. If this information is not provided, you may be asked to either reschedule your appointment or pay for your visit at the time of service.

9. **REFERRALS:** If you have an HMO plan with which we are contracted, you need to obtain a referral from your primary care physician prior to your appointment. If we have not received a referral prior to your arrival at the office, you will be rescheduled or asked to sign a waiver assuming all financial liability for the visit.

10. **NONPAYMENT:** Your communication and involvement to ensure your balance is paid timely is important to us. It is imperative that you maintain communications and fulfill your financial agreement and arrangements to keep your account active and in good standing. Compass Medical reserves the right to deny future non-emergency treatment for any and all debtor-related unpaid account balances until the balance is paid in full. In addition, providers may no longer be able to continue providing you with care because of nonpayment. If your account balance becomes 90 days past due, further steps to collect this debt may be taken, including reporting the account to a collection agency. If the provider is unable to continue providing care because of nonpayment, you will be notified by mail that you have 30 days to pay the balance in full or find alternative medical care. During that 30 day period, our physician will only be able to treat you on an emergency basis or until you are no longer in an acute phase of treatment or in the process of medical workup for diagnosis.

11. **MISSED APPOINTMENTS:** Please be aware that your office *may* charge a fee for any appointments not canceled within 24 hours. For more information on your site's specific policy, please contact your site directly. Any fees incurred due to missed appointments without prior cancelation will be your responsibility and billed directly to you.

12. **PAYMENT OPTIONS:** We accept MasterCard, Visa and Discover, cash, checks or debit cards. We also can set up a budget payment plan if your entire balance cannot be paid in full within 30 days. Please contact our Billing Department at (508) 350-2450 to set up a budget plan.

I HAVE READ AND UNDERSTAND THE PAYMENT POLICY AND AGREE TO ABIDE BY ITS GUIDELINES.

Signature of Patient or Responsible Party: _____ **Date**: _____

For Office Use Only

Account #: _____

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Patient Name:_____ **Date of Birth:**_____ **Date:** _____

MEDICATION HISTORY

Please list all prescriptions, over-the-counter medications, herbal supplements, etc. that you are currently taking.
Please use the back of page if you need additional space.

	Medication Name	Dose *(ex: 25mg)*	How do you take this medication? *(ex: one tab twice per day)*	What do you take this for? *(ex: blood pressure)*
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

PREFERRED PHARMACY

Please list as #1 your *PREFERRED PHARMACY* for all maintenance medications.
List #2 a secondary pharmacy ONLY if you use a local pharmacy for same day prescriptions, not preferred MAILAWAY

	Pharmacy Name	Pharmacy Address (street/town)	Pharmacy Phone
1			
2			

For Office Use Only

Account #: _____

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Patient Name:_____ **Date of Birth:**_____ **Date:** _____

ALLERGY HISTORY

Please list all/any allergies you have had in your lifetime. Allergies to medication, food, environmental, seasonal etc.

Type of Allergy	Reaction

SURGICAL HISTORY

Please list all surgical procedures you have had in your lifetime.

Type of Surgery	Surgeon	Date of Surgery

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LIST OF CURRENT SPECIALISTS

Please list the following information for all the specialist that you are currently seeing.

Specialist Name	Specialty	Reason/Diagnosis	For How Long

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Patient Name:_____ DOB:_____ DATE: _____

FAMILY HISTORY

Please list your biological family members who are/were affected by the following conditions

FAMILY MEMBER	YOB	AGE	DIAGNOSIS (Mark all that apply with the year of diagnosis)			OTHER CONDITION
Mother ⌋ Living ⌋ Deceased			_____Diabetes _____Hypertension _____Heart Disease	_____Breast Cancer _____Colon Cancer _____Ovarian Cancer	_____Mental Illness _____Drug/Alcohol Abuse	
Father ⌋ Living ⌋ Deceased			_____Diabetes _____Hypertension _____Heart Disease	_____Breast Cancer _____Colon Cancer _____Ovarian Cancer	_____Mental Illness _____Drug/Alcohol Abuse	
Sister 1 ⌋ Living ⌋ Deceased			_____Diabetes _____Hypertension _____Heart Disease	_____Breast Cancer _____Colon Cancer _____Ovarian Cancer	_____Mental Illness _____Drug/Alcohol Abuse	
Brother 1 ⌋ Living ⌋ Deceased			_____Diabetes _____Hypertension _____Heart Disease	_____Breast Cancer _____Colon Cancer _____Ovarian Cancer	_____Mental Illness _____Drug/Alcohol Abuse	
Sister 2 ⌋ Living ⌋ Deceased			_____Diabetes _____Hypertension _____Heart Disease	_____Breast Cancer _____Colon Cancer _____Ovarian Cancer	_____Mental Illness _____Drug/Alcohol Abuse	
Brother 2 ⌋ Living ⌋ Deceased			_____Diabetes _____Hypertension _____Heart Disease	_____Breast Cancer _____Colon Cancer _____Ovarian Cancer	_____Mental Illness _____Drug/Alcohol Abuse	
Sister 3 ⌋ Living ⌋ Deceased			_____Diabetes _____Hypertension _____Heart Disease	_____Breast Cancer _____Colon Cancer _____Ovarian Cancer	_____Mental Illness _____Drug/Alcohol Abuse	
Brother 3 ⌋ Living ⌋ Deceased			_____Diabetes _____Hypertension _____Heart Disease	_____Breast Cancer _____Colon Cancer _____Ovarian Cancer	_____Mental Illness _____Drug/Alcohol Abuse	
Maternal Grandmother ⌋ Living ⌋ Deceased			_____Diabetes _____Hypertension _____Heart Disease	_____Breast Cancer _____Colon Cancer _____Ovarian Cancer	_____Mental Illness _____Drug/Alcohol Abuse	
Maternal Grandfather ⌋ Living ⌋ Deceased			_____Diabetes _____Hypertension _____Heart Disease	_____Breast Cancer _____Colon Cancer _____Ovarian Cancer	_____Mental Illness _____Drug/Alcohol Abuse	
Maternal Aunt ⌋ Living ⌋ Deceased			_____Diabetes _____Hypertension _____Heart Disease	_____Breast Cancer _____Colon Cancer _____Ovarian Cancer	_____Mental Illness _____Drug/Alcohol Abuse	
Maternal Uncle ⌋ Living ⌋ Deceased			_____Diabetes _____Hypertension _____Heart Disease	_____Breast Cancer _____Colon Cancer _____Ovarian Cancer	_____Mental Illness _____Drug/Alcohol Abuse	
Paternal Grandmother ⌋ Living ⌋ Deceased			_____Diabetes _____Hypertension _____Heart Disease	_____Breast Cancer _____Colon Cancer _____Ovarian Cancer	_____Mental Illness _____Drug/Alcohol Abuse	
Paternal Grandfather ⌋ Living ⌋ Deceased			_____Diabetes _____Hypertension _____Heart Disease	_____Breast Cancer _____Colon Cancer _____Ovarian Cancer	_____Mental Illness _____Drug/Alcohol Abuse	
Paternal Aunt ⌋ Living ⌋ Deceased			_____Diabetes _____Hypertension _____Heart Disease	_____Breast Cancer _____Colon Cancer _____Ovarian Cancer	_____Mental Illness _____Drug/Alcohol Abuse	
Paternal Uncle ⌋ Living ⌋ Deceased			_____Diabetes _____Hypertension _____Heart Disease	_____Breast Cancer _____Colon Cancer _____Ovarian Cancer	_____Mental Illness _____Drug/Alcohol Abuse	
Daughter ⌋ Living ⌋ Deceased			_____Diabetes _____Hypertension _____Heart Disease	_____Breast Cancer _____Colon Cancer _____Ovarian Cancer	_____Mental Illness _____Drug/Alcohol Abuse	
Son ⌋ Living ⌋ Deceased			_____Diabetes _____Hypertension _____Heart Disease	_____Breast Cancer _____Colon Cancer _____Ovarian Cancer	_____Mental Illness _____Drug/Alcohol Abuse	

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Medical Record # _____
To be completed by Compass Medical Staff

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CONSENT TO DISCLOSE PROTECTIVE HEALTH INFORMATION TO FAMILY, FRIENDS, AND/OR OTHER REPRESENTATIVES

THIS FORM IS OPTIONAL

Patient Name:_____ Date of Birth: _____

By signing below, I hereby authorize Compass Medical, P.C. to disclose my protected health information (PHI) to the following family members, friends etc.

Name	*Relationship*	*Phone Number*
_____	_____	_____
_____	_____	_____
_____	_____	_____

Patient Signature:_____ Today's Date: _____

By signing below, I hereby authorize the Providers and staff at Compass Medical, P.C. to leave information on my answering machine.

Patient Signature:_____ Today's Date: _____

Note: This form will be in effect until a verbal or written request has been received to revoke and/or change.

**The U.S. Department of Health and Human Services (HHS) issued the Privacy Rule under the governance of the Office of Civil Rights. The Privacy rules defines and limits the circumstances in which an individual's protected health information (PHI) may be used or disclosed. By completing this form, you are authorizing Compass Medical Providers and Staff to communicate with the individuals you have identified above about your Protected Health Information (PHI).*

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AUTHORIZATION FOR ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION

Compass Medical will happily file your claim with your insurance company as a courtesy. Compass Medical bills your insurance in accordance with all federal, state and other contractual requirements. I authorize Compass Medical to release all necessary information to my insurance carrier, and I assign payment of my Medical Benefits to Compass Medical. If your insurance company sends payments directly to you, send or drop-off the payment to Compass Medical Billing and we will apply it to your account.

By signing my name below, I agree to the above information.

_____

Signature of Patient or Responsible Party (see Patient Registration form for Documentation)

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BACTES™
a sharecare company

Compass Medical, P.C. Medical Record Information

Compass Medical has partnered with a Bactes, a leader in release of information solutions, to help orchestrate all Medical Record Requests. Please refer to the frequently asked questions below for information on how to obtain a copy of your medical record, the cost, and the process.

The cost for reproduction on medical record requests is quite extensive, therefore, in order to fulfill your request, Bactes must ask for an upfront fee according to Massachusetts Statute. This fee is geared to off-set the rising costs associated with copying, tracking and reporting processes surrounding your request. Please contact Bactes directly for any questions or concerns regarding this fee.

Frequently Asked Questions

How can I obtain a copy of my medical record?
Complete the CMPC "Authorization for use or disclosure of Medical Record Information". Please forward this completed request to the MD office of the records that you are requesting.

Is there a cost to obtain a copy of my medical record?
Yes, there may be a charge to obtain a copy of your medical record. The cost is based on the following:

- the information requested
- the number of pages reproduced
- postage

The copy fee is in accordance with the Massachusetts law (MGL Chapter 111: Section 70).
Alternatively, you may request an 'abstract' of your medical record, which contains immunizations, two (2) years of office visits and labs, and five (5) years of radiology and diagnostic reports. The maximum fee for the abstract is $25.00 or the MA Statute whichever is less. The abstract is usually sufficient to meet the need of many requests. Additional options and pricing can be found on the medical record request form.

How can I submit my payment?
You will receive an invoice from our release of information vendor, Bactes, shortly after we receive your request. Please note that Bactes accepts MasterCard, Visa, American Express, Discover and check or money order for payment. Unfortunately, Flex Health spending cards cannot be used for payment.

How soon can I expect the release of my medical record to be completed?
Processing time varies depending on the type of request; routine requests are usually completed within seven business days, assuming payment has been received.

Can I get my records sent to me electronically?
Yes, Bactes will provide a copy of your medical records via CD or secure email at no additional cost. Please contact Bactes directly if this is the preferred method of receiving records.

How can I get a copy of my medical record from my former doctor to my new Compass Medical, P.C. doctor?
If you need medical records from a previous doctor mailed to us, we will be happy to assist you. Simply complete the CMPC, Authorization for use or disclosure of Medical Record Information" form and send it to your previous doctor. If provided with the mailing address, we will be happy to mail it for you. It is recommended that you contact your previous provider to obtain their medical record processing details as fees may apply.

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Authorization to Use & Disclose Protected Health Information

Steward

Location:_____
Address:_____
City, Zip_____

Patient Information

Patient Name (Please Print):_____ Date of Birth: _____
Any other Previous Names: _____
Patient Address:_____ Phone #'s:_____
City:_____ State:_____ Zip:_____ EMAIL: _____
Your Compass Medical Doctor's Name that you are requesting records from: _____

I hereby Authorize Compass Medical to:

Please choose one: ○ Release my medical record information to ○ Obtain medical information from

Name/Facility:_____ Attention:_____
Address:_____ Phone #: _____
City:_____ State:_____ Zip:_____ Fax #: _____

Purpose of Request: ○ Personal ○ Referral or 2nd Opinion ○ Legal ○ Insurance ○ Other_____
○ Transfer from Practice/Reason?_____.

Specific Records/Report(s) to be released:

○ Provide a 2 year abstract of my records. An abstract is the lesser of $ 25.00 or amount allowed by state statute, plus postage.
○ Provide a copy of my full electronic record. A full record is the lesser of $ 50.00 or amount allowed by state statute, plus postage.
○ Other - be specific, include dates and MD's under comments. You will be invoiced at the amount allowed by state statute.

Please do not prepay. You will be invoiced for your selection by our vendor.

COPY FEE: *Pursuant to each respective state statute, we reserve the right to charge a reasonable fee for the cost of producing and mailing the copies. Massachusetts Chapter 111, Section 70*

Restricted Authorization to Release Protected Information:

STOP **IMPORTANT -** It is extremely important that you select either you "**DO**" or "**DO NOT**" for each item contained in this section *Authorization to Release Protected Information*. Please do not skip any line item as it could impact our ability to fulfill your request and cause additional delays.

Release Records? Check one

I ☐ **DO** ☐ **DO NOT** want **Mental/Behavior Health or Disability Services Provider Documentation** * released.
I ☐ **DO** ☐ **DO NOT** want **HIV/AIDS Screening Test Results** released
I ☐ **DO** ☐ **DO NOT** want information about **Alcohol and/or Substance Abuse Treatment** *** released
I ☐ **DO** ☐ **DO NOT** want **Genetic Testing/Test Results** ** released
I ☐ **DO** ☐ **DO NOT** want **Confidential Communications with a Social Worker** released
I ☐ **DO** ☐ **DO NOT** want information about **Rape/Sexual Assult Victim's Counseling** released
I ☐ **DO** ☐ **DO NOT** want **Child/Elder Abuse or Neglect & Abuse of an Adult with a Disability** released
I ☐ **DO** ☐ **DO NOT** want information about **Sexually Transmitted Disease (STD's)** released
I ☐ **DO** ☐ **DO NOT** want information about **Domestic Violence Victim's Counseling** released

* This Authorization is not valid for use or disclosure of psychotherapy notes.

** The term "genetic tests" means only those tests which determine your future chances of developing a disease, not test done to diagnose a current condition or problem. This includes information related to the testing of embryo's created during IVF.

*** Only applicable to records that are created by an "individual or entity who holds itself out as providing alcohol or drug abuse diagnosis, treatment or referral for treatment" (42 CFR Part 2). Does not include records created or maintained by a general medical facility.

Sign Here _____ Date Here _____

Signature of Patient's **Date**

Signature of Personal Representative **Date** **Relationship to patient or authority to act for patient**

Term: This Authorization will remain in effect until Compass Medical fulfills this request.
Revocation: I understand that I may revoke this Authorization at any time by requesting it of Compass Medical in writing at the address listed below. The revocation will be effective immediately upon Compass Medical's receipt of my written notice. I understand that the revocation will not have any effect on any action taken by Compass Medical in reliance on this Authorization before it received my written notice of revocation.
Written Notice is to be mailed to: ADDRESS INSERTED HERE
Effect on Treatment: I understand that I may refuse to sign this Authorization for any reason and that such refusal will not affect the commencement, continuation or quality of my treatment at Compass Medical
Potential for Redisclosure: I understand that the person receiving my Protected Health Information may not be required to comply with federal and state Privacy laws, and my Protected Health Information may no longer be protected by the applicable state and federal law once it is disclosed by Compass Medical.
Access: I understand that in certain circumstances Compass Medical has the right to deny me access to all or portions of my Protected Health Information and must notify me in writing of any such denials.

Rev. 05/2016

NOTICE OF PRIVACY RIGHTS & 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.

We create records of the health care and services you receive from us and we are committed to protecting that medical information. We are required by law to protect the privacy of any medical information that identifies you; provide you with this notice describing our legal duties and privacy practices with respect to your medical information; and to follow the terms of the most current Steward privacy notice.

1. **Who Will Follow This Notice**

   This notice describes the privacy practices of the Affiliated Covered Entities in Steward Health Care System ("Steward") and applies to all of the Steward Health Care System hospitals and other health care providers in Massachusetts, New Hampshire and Rhode Island, including their employees, students and volunteers. Collectively Steward's Affiliated Covered Entities and individuals are referred to as "we" or "us" in this notice. Steward's Affiliated Covered Entities also work in a coordinated fashion with other providers who participate in an Organized Health Care Arrangement with the Steward Affiliated Covered Entities.

2. **How We Use and Disclose Your Medical Information Without Your Written Permission**

   We use and disclose your medical information to conduct many activities that are common in hospitals and other types of health care providers. In certain situations, which are described below in Section 3, we are required to obtain your written permission to use or disclose your medical information. The following are different situations in which we may use or disclose your medical information without your written permission.

   - **Treatment:** We use and disclose your medical information to provide, coordinate or manage your medical treatment and related services. For example, a physician will use your test results to diagnose and treat your injury or illness. We may share medical information with providers outside Steward such as a referring physician who is treating you.
   - **Payment:** We use and disclose your medical information so that we can obtain payment for health care services that we provide to you. For example, we may provide information about your treatment to your insurer or other company or program that arranges or pays for your health care, in order to obtain their prior approval and authorization for the treatment.
   - **Health Care Operations:** We use and disclose your medical information to support our efforts to improve the quality or cost of care and for our own management and planning. For example, we may use your medical information to measure the performance of our staff in how they care for you. We may also share your medical information with our business associates with whom we have contracted to provide services, such as a billing company or medical transcription service.
   - **Other Health Care Providers:** We may also share medical information with your doctor and other health care providers who are not part of Steward when they need it to provide Treatment to you, to obtain Payment for the care they give to you, to perform certain Health Care Operations, such as reviewing the quality and skill of health care professionals, or to review their actions in following the law.
   - **Use or Disclosure for Directory Purposes for Patients in Steward Hospitals:** We may include your name, location in the hospital, general health condition and religious affiliation in a patient directory without receiving your permission unless you tell us you do not want your information in the directory. Information in the directory may be shared with anyone who asks for you by name or with members of the clergy; however, religious affiliation will only be shared with members of the clergy.

- **Disclosure to Family, Friends and Other Caregivers:** We may share your medical information with a family member, a close personal friend, or another person who you identify if we (1) first provide you with the chance to object to the disclosure and you do not object; (2) infer that you do not object to the disclosure; or (3) obtain your agreement to share your medical information with these individuals. The medical information we share will be limited to the information necessary for that person's involvement with your care or payment for your health care. We may also use or share your medical information with an organization, such as the American Red Cross, assisting in a disaster relief effort, to notify (or assist in notifying) your family about your location and general condition. In the event you are deceased, and unless we know that you would object, we may share your medical information with a family member or a close personal friend that was involved with your care or payment for your health care. The medical information we share will be limited to the information necessary for that person's involvement with your care or payment for your health care.
- **Public Health Activities:** We are required or are permitted by law to report medical information to certain government agencies and others. For example, we may disclose your medical information for the following:
    - To report health information to public health authorities for the purpose of preventing or controlling disease, injury, or disability;
    - To report abuse and neglect to government authorities or social agencies that are legally permitted to receive the reports;
    - To report information about products and services to the U.S. Food and Drug Administration;
    - To alert a person who may have been exposed to a communicable disease or may otherwise be at risk of developing or spreading a disease or condition;
    - To report information to your employer as required under laws addressing work-related illnesses and injuries or workplace medical surveillance; and
    - To prevent or lessen a serious and imminent threat to a person for the public's health or safety, or to certain government agencies with special functions such as the State Department.
- **Health Oversight Activities:** We may disclose your medical information to local, state or federal authorities that are responsible for the oversight of health care related matters, such as agencies administering Medicare and Medicaid.
- **Judicial and Administrative Proceedings:** We may disclose your medical information in the course of a judicial or administrative proceeding in response to a legal order or other lawful process, to the extent the disclosure is authorized by a court, tribunal, or, in certain circumstances, to a subpoena, discovery request or other lawful process.
- **Law Enforcement Purposes:** We may disclose your medical information to the police or other law enforcement officials as required or permitted by law as part of law enforcement activities and investigations.
- **Decedents:** We may disclose your medical information to a coroner or medical examiner as authorized by law, and we may disclose medical information to funeral directors so they may carry out their obligations.
- **Organ and Tissue Procurement:** We may disclose your medical information with organizations that facilitate organ, eye, or tissue procurement, banking, or transplantation.
- **Military and Veterans:** If you are in the U.S. or foreign armed services, or a veteran, we may disclose your medical information as required by the proper military authority so that they may carry out their lawful duties.
- **National Security:** We may disclose your medical information to the appropriate federal officials for the protection of the President, to other authorized persons, to conduct special investigations or for intelligence, counter-intelligence and other national security purposes.
- **Inmates:** If you are an inmate in a correctional facility or in the custody of a law enforcement official, we may disclose your medical information to the correctional facility or law enforcement officer so that they may carry out their lawful duties.
- **Research:** We may use or share your medical information if the group that oversees our research, the Institutional Review Board/ Privacy Board, approves a waiver of permission (authorization) for disclosure or for a researcher to begin the research process.
- **Workers' Compensation:** We may disclose your medical information as permitted by or required by state law relating to workers' compensation or other similar programs.
- **As Required by Law:** We may use and disclose your medical information when required to do so by federal, state or local law.

3. **Uses and Disclosures Requiring Your Written Permission (Authorization)**

We are required to obtain your written permission to use or disclose your medical information for the following reasons. You may revoke an authorization at any time, in writing, except to the extent that we have acted in reliance on it.

- **Use or Disclosure with Your Permission (Authorization):** For any purpose other than the ones described in Section 2, we may only use or share your medical information when you grant us your written permission (Authorization).
- **Marketing and Sale of Your Medical Information:** We must also obtain your Authorization prior to using or disclosing your medical information to send you any marketing materials. However, we may communicate with you about products or services related to your Treatment, case management or care coordination, or alternative treatments, therapies, health care providers, or care settings without your permission. In addition, we are prohibited from selling your medical information without your written authorization to do so.
- **Uses and Disclosures of Your Highly Confidential Information:** Federal and state law may require special privacy protections for any portion of your medical information that is considered "highly confidential information", including, to the extent applicable, records regarding: (1) psychotherapy notes; (2) mental health and developmental disabilities services; (3) alcohol and drug treatment; (4) HIV/AIDS testing; (5) sexually transmitted disease(s); (6) genetic testing; (7) child abuse and neglect; (8) abuse of an adult with a disability; (9) sexual assault; or (10) invitro fertilization (IVF). Before sharing your Highly Confidential Information for a purpose other than as permitted by law, we must obtain your written permission.

4. **How Long We Keep Your Medical Information**

Steward Affiliated Covered Entities maintain medical records for the period of time required by law. Copies of applicable record retention policies are available upon request.

5. **Your Rights Regarding Your Medical Information**

With respect to the medical information maintained by Steward, you have the right:

- To see and get a copy of your medical information that is used to make decisions about your care and treatment, including your medical and billing records. Under certain circumstances, we may deny your request. If we do so, we will send you a written notice describing the basis of our denial. Requests must be made in writing. We may charge a reasonable fee for copying, mailing or other expenses associated with processing a request. If your medical information is maintained electronically, you may request a copy of the information in an electronic format.
- To request a change or amendment to your medical information. Requests for an amendment must be made in writing and provide a reason to support the requested amendment. We may deny your request under certain circumstances. If we deny your request, we will send you a written notice of denial. This notice will describe the reason for our denial and your right to submit a written statement disagreeing with the denial.
- To receive an accounting of disclosures of your medical information. Requests for an accounting must be made in writing. An accounting will only include disclosures made during the time period indicated on the request, but may not exceed a period of six years.
- To request that we restrict or limit our use or disclosure of your medical information. We are generally not required to agree to your request, however we will consider them. We must, however, agree to your request to restrict the disclosure of your medical information to a health plan if the medical information pertains solely to a health care item or service for which you or a person other than a health plan has paid for in full at time of service. Please note that in certain cases, other law may not permit us to agree to a requested restriction.

- To receive confidential communications at a phone number or address other than your home. We will accommodate your request if your request is reasonable and you specify an alternative means or location.
- To receive notice if we discover a breach of your unsecured medical information and notification is required by law.
- To receive a paper copy of this notice, upon request, even if you have agreed to receive it electronically.
- To revoke an authorization at any time, in writing, except to the extent that we have acted in reliance on the authorization.

6. **Effective Date and Changes to this Notice**

This notice takes effect June 1, 2018. We reserve the right to change this notice and our privacy practices, policies and procedures and to make the new notice, practices, policies and procedures effective for all medical information we already have as well as any we create or receive in the future. If we make any changes to the notice, we will publish the revised notice on the Steward website at www.steward.org and post it in common areas in our hospitals, physician practices and other patient care facilities.

7. **Questions and Complaints**

Please contact the Office of Corporate Compliance & Privacy to request a copy of this notice, to obtain help understanding this notice or to obtain more information. You may also contact a Privacy Officer if you are concerned that your privacy rights have been violated or if you disagree with a decision that was made about access to your medical information. A Privacy Officer can be reached by phone at 1-617-419-4732, or in writing at Privacy Officer, Steward Health Care System, 1900 N. Pearl Street, Suite 2400, Dallas, TX 75201.

Written complaints may also be filed with the Office for Civil Rights, U.S. Department of Health and Human Services. Filing a complaint will not affect the treatment or services you receive from us.