Patient Information

Today's Date: ____/_____/_____ Birth Date ____/_____/_____ Gender ☐ M ☐ F Social Security: _____/_____/_____

First Name: _____ M.I. _____ Last Name _____

Marital Status: ☐ Single ☐ Married ☐ Other **Email Address:** _____

Home Address._____ City _____ ST _____ Zip _____

Phone Numbers (home): _____-_____-_____ (cell): _____-_____-_____ (work): _____-_____-_____

Is your injury due to a car accident or work related injury? ☐ Yes ☐ No **Do you have an attorney for your injury?** ☐ Yes ☐ No

If YES to the above questions, please STOP and contact the FRONT OFFICE!

Messages can be left on: ☐ Home ☐ Cell ☐ Work

Employer / School Name or Affiliation: _____

☐ Employed ☐ Unemployed ☐ Disabled ☐ Retired ☐ Student

May we leave message with family members? ☐ Yes ☐ No If "YES" Names _____

Emergency Contact Name: _____ Relation to Patient: _____

Emergency Contact Phone: _____-_____-_____

Information below is collected pursuant to the requirements of the TN Dept. of Health in compliance with TN State Law. (PLEASE ANSWER BOTH)

1. RACE: ☐ White ☐ Black/African American ☐ American Indian or Alaska Native ☐ Asian or Pacific Islander ☐ Hispanic ☐ Asian ☐ Unknown Race

2. ETHNICITY: ☐ Hispanic Origin ☐ Not Hispanic Origin ☐ Unknown If of Hispanic Origin

Person responsible for the account: ☐ **SELF**

Name: _____ SSN: _____/_____/_____ DOB: ____/_____/_____

Relation to Patient: _____ Address (if different from patient): _____

Guarantor- Employment Status: ☐ Employed ☐ FT Student ☐ PT Student ☐ Self Employed ☐ Retired

Guarantor's Employer Name: _____ Employer Phone: _____-_____-_____

DO YOU HAVE INSURANCE?: ☐ **YES** ☐ **NO**

Primary Insurance Co.: _____ Group#: _____ Policy#: _____

Name of Insured: _____ SSN: _____/_____/_____ DOB: ____/_____/_____

Relation to Patient: _____

Secondary Insurance Co.: _____ Group#: _____ Policy#: _____

Who referred you to our office: _____ **Primary Care Physician:** _____

Phone: _____-_____-_____

Are you in Pain Management? ☐ YES ☐ NO If YES, Where? _____

Are you under the care of other physicians or specialists? ☐ YES ☐ NO

PHARMACY NAME: _____ City: _____ ST:_____ Phone: _____-_____-_____

RiverRun HEALTH
ORTHO NORTH

Financial Policy

This is an agreement between AdvancedHEALTH, as creditor, and the Patient/Debtor named on this form and indicated by patient/debtor signature below.

In this agreement the words “you”, “your” and “yours” mean Patient/Debtor. The word “account” means the account that has been established in your name to which the charges are made and payments credited. The words “we”, “us” and “our” refer to AdvancedHEALTH. By executing this agreement, you are agreeing to pay for all services that are rendered.

Effective Date: once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect. A copy of your signed financial agreement will be provided to you.

Health Insurance- It is YOUR responsibility to:

- Ensure we have been provided with the most current insurance information relative to filing your claim including insurance card, ID number, employer, birth date and patient address. This information will be located on our patient registration form.
- Ensure we are contracted with your insurance carrier to receive maximum benefits.
- Pay your co-payment or patient portion at the time of service.
- Inform us of any insurance changes made after this signed agreement/date of service. Insurance carriers have specific timely guidelines and pre-authorization requirements for certain services. If revised insurance information is not provided to us within your insurances’ timely filing limits, you will be required to pay for services in full. If prior authorization we required for services already received and your claim is denied for lack of authorization, you will be required to pay for services in full.
- Contact your insurance company if no correspondence is received by you within 45 days of the date of service.

It is OUR responsibility to:

- Submit a claim to your health insurance carrier based on the information provided by the patient/debtor at the time of the service or as updated information is provided.
- Provide your health insurance carrier with information to determine benefits. This may include medical records and/or a copy of your insurance card.

PAYMENT OPTIONS: Per our contracted agreement with your insurance carrier, we are required to collect your Co-payment on the day of service. If you do not have insurance, you are required to pay for treatment at the time of service unless other arrangements have been formally made. A separate self-pay financial agreement will be provided to you.

We accept the following: CASH, CHECK, CREDIT CARD (Visa, MasterCard, Discover, and American Express)
A twenty-five ($25.00) returned check fee will be assessed to the patient account per incident.

For convenience, payments may be made online at **www.epayitonline.com.** To utilize this service you will need your account number, access code, and Code ID. This information can be found on the patient statement you will receive reflecting your balance.

DELINQUENT ACCOUNTS: We review past due accounts frequently and at every statement cycle. 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.

If your account becomes sixty (60) days past due, further steps to collect this debt may be taken. If you fail to pay on time and we refer your account(s) to a third party for collection, a collection fee will be assessed and will be due at the time of the referral to the third party. The fee will be calculated at the maximum percentage permitted by applicable law, not to exceed 18 percent. In addition, we reserve the right to deny future non-emergency treatment for any and all debtor-related unpaid account balances.

CONSENT TO CONTACT: I grant permission and consent to AdvancedHEALTH and its agents, assignees, and contractors (which may include third party debt collectors for past due obligations): (1) to contact me by phone at any number associated with me, if provided by me or another person on my behalf; (2) to leave messages for me and include in any such messages amounts owed by me; (3) to send me text message or emails using any email address I provided or any phone number associated with me, if provided by me or another person on my behalf; and (4) to use prerecorded/artificial voice messages and/or an automated telephone dialing system (an auto dialer) as defined by the Telephone Consumer Protection Act in connection with any communications made to me as provided herein or any related scheduled services and my account. I understand that my refusal to provide the consent described in this paragraph will not affect, directly or indirectly, my right to receive healthcare services.

Patient and/or Debtor Signature: _____ Date _____/_____/_____

Release Of Medical Information

NAME *(Please print)*: _____

By Signing Below, I Authorize RiverRun HEALTH Ortho North To Release My Medical And Billing Information To:

RELATIONSHIP			**NAME OF DESIGNATED PERSON**
SPOUSE	☐ YES	☐ NO	_____
CHILDREN	☐ YES	☐ NO	_____
IN-LAWS	☐ YES	☐ NO	_____
CAREGIVERS	☐ YES	☐ NO	_____
PARENTS	☐ YES	☐ NO	_____

OTHERS _____

PATIENT SIGNATURE _____ DATE _____/_____/_____

PARENT SIGNATURE _____ DATE _____/_____/_____

We ask that if you have any change in this request, that you please inform the receptionist.

RiverRun HEALTH Ortho North may leave appointment information on my voicemail:

HOME	☐ YES	☐ NO	_____
WORK	☐ YES	☐ NO	_____
RELATIVE	☐ YES	☐ NO	_____

PATIENT SIGNATURE _____ DATE _____/_____/_____

I authorize the following to pick up prescriptions, X-rays, etc.

RELATIONSHIP			
SPOUSE	☐ YES	☐ NO	_____
RELATIVE	☐ YES	☐ NO	_____
CAREGIVER	☐ YES	☐ NO	_____

PATIENT SIGNATURE _____ DATE _____/_____/_____

I understand that RiverRun HEALTH Ortho North will ask for identification of the person picking up patient medical information or products.

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Patient Evaluation

Patient Name:_____ **DOB:**_____/_____/_____ **Date:**_____/_____/_____

Is this due to a non-work related injury? ☐ Yes ☐ No

If yes, when? _____ where?_____ what time?_____

Is this due to a work injury? ☐ Yes ☐ No **If yes, Date of Injury** _____

Has this been reported to your employer? ☐ Yes ☐ No **Are you still working?** ☐ Yes ☐ No

Problem being seen for today: _____ ☐ Right ☐ Left

What symptoms are you experiencing?_____

_____

How long have you had this problem?_____

Have you experienced this problem in the past? ☐ Yes ☐ No If yes, please describe: _____

_____

What makes your pain *worse?*_____

_____

What makes your pain *better?*_____

Have seen another physician for this problem? ☐ Yes ☐ No Please explain: _____

_____

Have you had prior treatment for this problem? ☐ Yes ☐ No Please explain: _____

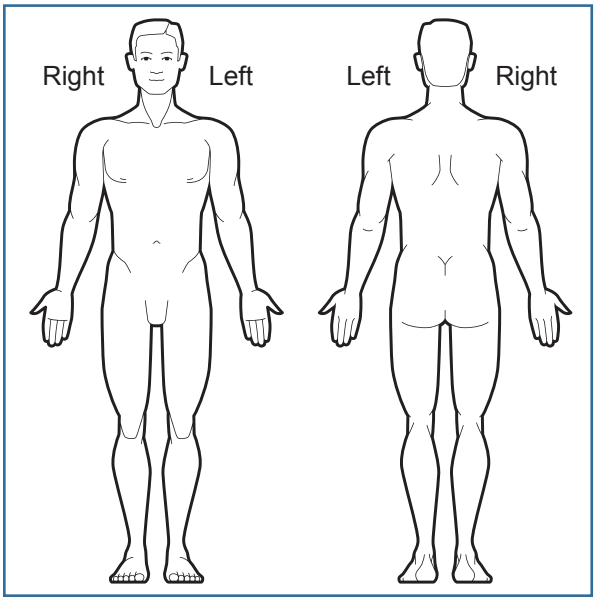
_____

Had any prior testing? (Please check) ☐ X-rays ☐ MRI ☐ CT Scan ☐ EMG ☐ DEXA (Bone scan)

If yes, Where? _____ When? _____

On the illustration below, please use the following symbols to explain your symptoms:

Aching ^ ^ ^ ^ Sharp < < < < Burning / / / / Dull Ache = = = = Numbness x x x x Pins/Needles * * * *



Pain Scale (Please Check)

☐ 0 **No pain**
☐ 1
☐ 2
☐ 3
☐ 4
☐ 5 **Moderate Pain**
☐ 6
☐ 7
☐ 8
☐ 9
☐ 10 **Severe Pain**

Height _____ Weight _____

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Medical Information

Patient Name:_____ **DOB:**____/____/_____ **Date:**____/____/_____

Height:_____ **Weight:**_____

Current Medications Including Prescriptions, Over the Counter Medications, Vitamins & Herbs

Name of Medication	Strength	Frequency	Condition

Please list Allergies to Medications, Dyes, Latex or Metals AND Reactions ie: rash, hives.

Please list Surgeries with Dates AND any hospitalizations.

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Medical History

Patient Name:_____ **DOB:**____ /____ /_____ **Date:**____ /____ /_____

REVIEW OF SYSTEMS: Have you recently experienced (Please Check):

Cardiovascular
- ☐ Chest Pain
- ☐ Dizziness
- ☐ Fluid Accumulation
- ☐ Irregular Heartbeat
- ☐ Shortness of Breath
- ☐ Palpitations

ENT
- ☐ Decreased Hearing
- ☐ Difficulty Swallowing
- ☐ Ringing in Ears
- ☐ Wears Dentures

Gastrointestinal
- ☐ Gastric Reflux/GERD
- ☐ Abdominal Pain
- ☐ Nausea
- ☐ Heartburn
- ☐ Blood in Stool

General/Constitutional
- ☐ Chills
- ☐ Cough
- ☐ Cold
- ☐ Fatigue
- ☐ Fever
- ☐ Headache
- ☐ Insomnia
- ☐ Significant Weight Gain
- ☐ Significant Weight Loss

Genitourinary
- ☐ Abdominal Pain
- ☐ Blood in Urine
- ☐ Difficulty Urinating
- ☐ Painful Urination
- ☐ Urinary Incontinence

Hematology
- ☐ Easy Bruising
- ☐ Recent Transfusion
- ☐ Prolonged Bleeding
- ☐ Anemia

Musculoskeletal
- ☐ Pain in Joints
- ☐ Swollen Joints
- ☐ Weakness
- ☐ Leg Cramps
- ☐ Joint Stiffness
- ☐ Muscle Aches

Neurologic
- ☐ Loss of Use of Extremity
- ☐ Low Back Pain
- ☐ Seizures
- ☐ Tremors
- ☐ Tingling/Numbness
- ☐ Balance Difficulty
- ☐ Gait Abnormality
- ☐ Loss of Strength
- ☐ Neck Pain

Ophthalmology
- ☐ Blurred Vision
- ☐ Wears Glasses
- ☐ Wears Contacts

Psychiatric
- ☐ Anxiety
- ☐ Depression
- ☐ Suicidal Ideation
- ☐ Claustrophobic
- ☐ Bipolar Disorder
- ☐ Difficulty Sleeping
- ☐ Substance Abuse
- ☐ Suicidal Thoughts
- ☐ Mental or Physical Abuse

Respiratory
- ☐ Cough
- ☐ Pain with Inspiration
- ☐ Shortness of Breath at Rest
- ☐ Shortness of Breath with Exertion
- ☐ Wheezing

Skin
- ☐ Color Change
- ☐ Pallor
- ☐ Rash _____
- ☐ Wound _____

PAST MEDICAL HISTORY (Please Check):

- ☐ Alzheimer's Disease
- ☐ Anemia
- ☐ Angina/Chest Pain
- ☐ Anxiety
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Autoimmune Disorder
- ☐ Blood Clots
- ☐ BPH/Enlarged Prostate
- ☐ Cancer Type_____
- ☐ Clotting Disorder
- ☐ COPD/Emphysema
- ☐ Crohn's Disease
- ☐ CVA/Stroke
- ☐ Depression
- ☐ Diabetes Type_____ Insulin Dependent_____
- ☐ Fibromyalgia
- ☐ Gallbladder Disease
- ☐ GERD/Acid Reflux
- ☐ Gout
- ☐ Hepatitis A____B____C____
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV/AIDS
- ☐ Insomnia
- ☐ Irritable Bowel Disease
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Lupus
- ☐ MI/Heart Attack
- ☐ Migraines
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Parkinson's Disease
- ☐ Peptic Ulcer Disease
- ☐ PTSD
- ☐ Recurrent UTI
- ☐ Rheumatoid
- ☐ Seizure Disorder
- ☐ Thyroid Disease
- ☐ Other: _____ _____ _____

Any Medical Conditions not listed? ☐ Yes ☐ No Please list: _____

Are you Pregnant or nursing? ☐ Yes ☐ No If yes, details: _____

FAMILY HISTORY:

Please list diagnosed family health problems

Father ☐ Alive ☐ Deceased age _____ _____

Mother ☐ Alive ☐ Deceased age _____ _____

Siblings How many brothers? _____ Sisters? _____ _____

Children How many sons? _____ Daughters? _____ _____

_____

_____

_____

Social History

Patient Name:_____ **DOB:**____/____/_____ **Date:**____/____/_____

Do you smoke? ☐ No ☐ Never ☐ Yes ☐ Quit Age Started _____ Year Stopped _____

How many packs per day? _____ ☐ E-cigarette _____ ☐ Vape _____ ☐ Other _____

Alcohol Use? ☐ No ☐ Yes

Did you have a drink containing alcohol in the past year? ☐ Yes ☐ No

If Yes: How often did you have a drink containing alcohol in the past year?

☐ Never ☐ Occasionally ☐ Moderate

If Yes: How many drinks did you have on a typical day when you were drinking in the past year?

☐ Never ☐ Occasionally ☐ Moderate

If Yes: How often did you have 6 or more drinks on one occasion in the past year?

☐ Never ☐ Occasionally ☐ Moderate

Previous drug abuse? ☐ Yes ☐ No

If yes, list details _____

_____

_____

Employed? ☐ Yes ☐ No Please check: ☐ Full ☐ Part Time ☐ Retired ☐ Disabled ☐ Student

Occupation: _____

Job Duties: _____

Do you use assistive devices? ☐ None ☐ Cane ☐ Walker ☐ Crutches ☐ Wheelchair

Are you: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Partner

Do you live alone? ☐ Yes ☐ No If no, who do you live with?_____

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General Consent For Treatment

As the patient, you have the right to be informed about your conditions and the recommended surgical, medical, or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify appropriate treatment and/or procedure for any identified condition(s).

I request and authorize medical care as my provider, his assistant or designees (collectively called "the providers") may deem necessary or advisable. This care may include, but is not limited to, routine diagnostics, radiology and laboratory procedures, administration of routine drugs, biological and other therapeutics, and routine medical and nursing care. I authorize my provider(s) to perform other additional or extended services in emergency situations if it may be necessary or advisable in order to preserve my life or health. I understand that my (the patient) care is directed by my provider(s) and that other personnel render care and services to me (the patient) according to the provider(s) instructions.

I understand that I have the right and the opportunity to discuss alternative plans of treatment with my provider and to ask and have answered to my satisfaction any questions or concerns.

In the event that a healthcare worker is exposed to my blood or bodily fluid in a way which may transmit HIV (human immunodeficiency virus), hepatitis B virus or hepatitis C, I consent to the testing of my blood and/or bodily fluids for these infections and the reporting of my test results to the healthcare worker who has been exposed. _____ **(initial)**

I HAVE READ OR HAD READ TO ME AND FULLY UNDERSTAND THIS CONSENT; I HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS AND HAD THESE QUESTIONS ADDRESSED.

Name of Patient: _____

Signature of Patient: _____ Date _____/_____/_____

☐ Consent of Legal Guardian, Patient Advocate or Nearest Relative **if patient is unable to sign**

☐ Consent Caregiver **if patient is unable to sign**

Name of Legal Guardian, Patient Advocate, Nearest Relative or Other: _____

Relationship: _____ Telephone: _____

Address: _____

Signature of the above: _____ Date ____/____/_____ Time: _____ : _____

Signature of Witness: _____ Date _____/_____/_____

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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.

The Health Insurance Portability and Accountability Act (HIPAA; "Act") of 1996, revised in 2013, requires us as your health care provider to maintain the privacy of your protected health information, to provide you with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We are required to maintain these records of your health care and to maintain confidentiality of these records.

The Act also allows us to use your information for treatment, payment, and certain health operations unless otherwise prohibited by law and without your authorization.

- **Treatment:** We may disclose your protected health information to you and to our staff or to other health care providers in order to get you the care you need. This includes information that may go to the pharmacy to get your prescription filled, to a diagnostic center to assist with your diagnosis, or to the hospital should you need to be admitted. If necessary to ensure that you get this care, we may also discuss the minimum necessary with friends or family members involved in your care unless you request otherwise.

- **Payment:** We may send information to you or to your health plan in order to receive payment for the service or item we delivered. We may discuss the minimum necessary with friends or family members involved in your payment unless you request otherwise.

- **Health operations:** We are allowed to use or disclose your protected health information to train new health care workers, to evaluate the health care delivered, to improve our business development, or for other internal needs.

- We are required to disclose information as required by law, such as public health regulations, health care oversight activities, certain law suits and law enforcement.

Certain ways that your protected health information could be used and disclosed require an authorization from you: use or disclosure of your information for marketing, disclosures or uses that constitute a sale of protected health information, and any uses or disclosures not described in this NPP. We cannot disclose your protected health information to your employer or to your school without your authorization unless required by law. You will receive a copy of your authorization and may revoke the authorization in writing. We will honor that revocation beginning the date we receive the written signed revocation.

You have several rights concerning your protected health information. When you wish to use one of these rights, please inform our office so that we may give you the correct form for documenting your request.

- You have the right to access your records and/or to receive a copy of your records. Your request must be in writing, and we must verify your identity before allowing the requested access. We are required to allow the access or provide the copy within 30 days of your request. We may provide the copy to you or to your designee in an electronic format acceptable to you or as a hard copy. We may charge you our cost for making and providing the copy. If your request is denied, you may request a review of this denial by a licensed health care provider.

- You have the right to request restrictions on how your protected health information is used for treatment, payment, and health operations. For example, you may request that a certain friend or family member not have access to this information. We are not required to agree to this request, but if we agree to your request, we are obligated to fulfill the request, except in an emergency where this restriction might interfere with your care. We may terminate these restrictions if necessary to fulfill treatment and payment.

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- We are required to grant your request for restriction if the requested restriction applies only to information that would be submitted to a health plan for payment for a health care service or item for which you have paid in full out-of-pocket, and if the restriction is not otherwise forbidden by law. For example, we are required to submit information to federal health plans and managed care organizations even if you request a restriction. We must have your restriction documented prior to initiating the service. Some exceptions may apply, so ask for a form to request the restriction and to get additional information. We are not required to inform other covered entities of this request, but we are not allowed to use or disclose information that has been restricted to business associates that may disclose the information to the health plan.
- You have the right to request confidential communications. For example, you may prefer that we call your cell phone number rather than your home phone. These requests must be in writing, may be revoked in writing, and must give us an effective means of communication for us to comply. If the alternate means of communications incurs additional cost, that cost will be passed on to you.
- Your medical records are legal documents that provide crucial information regarding your care. You have the right to request an amendment to your medical records, but you must make this request in writing and understand that we are not required to grant this request.
- You have the right to an accounting of disclosures. This will tell you how we have used or disclosed your protected health information. We are required to inform you of a breach that may have affected your protected health information.
- You have the right to receive a copy of this notice, either electronic or paper or both.
- You have the right to opt out of fund raising communications.

If you have any questions about our privacy practices, please contact our Privacy Officer at the number below.

You have the right to file a complaint with us or with the Office for Civil Rights. We will not discriminate or retaliate in any way for this action. To file a complaint, please contact the applicable party:

Privacy Officer:	Ryan D. Brown
Mailing Address:	28 White Bridge Pike, Suite 111, Nashville, Tennessee 37205
Telephone:	615.986.6153
Fax:	615.234.1515
Email	Ryan.Brown@OurAdvancedHEALTH.com

Office for Civil Rights

http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html

We are required to abide by the policies stated in this Notice of Privacy Practices, which became effective on 9/11/18.

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Notice Of Privacy Practices Acknowledgement

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information (PHI). I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my PHI. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices.*

Patient Name or Legal Guardian: _____

Signature: _____

Date _____/_____/_____

PRACTICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement of the Notice of Privacy Practices Acknowledgement but was unable to do so as documented below:

Date _____/_____/_____ Initials:_____

Reason: _____

_____

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Patients' Rights

The patient's rights include:

- The right to receive a copy of the Notice of Privacy Practices
- The right to request confidential communications
- The right to request a restriction on the use and disclosure of PHI
- The right to know that the covered entity is not required to agree with the requested restriction unless the request is for a restriction of information to the health plan for a service or item which the patient pays for out of pocket, with no health plan involvement
- The right to inspect and copy the PHI
- The right to request amendments and corrections to the PHI
- The right to request an accounting of PHI disclosure

These are included in the Notice of Privacy Practices. Most require the patient to express their requests in writing. Providers have the authority to deny certain requests based on professional judgment.

Confidential Communications
Patients may request that the covered entity communicate with them through a method different than normally used, or to an alternate address or phone number, or through electronic means. However, the covered entity may require the patient to provide an effective means of contact, such as an address, phone number, or e-mail address, and may require the patient to explain how any additional costs to the practice will be paid. If the patient is unable to provide this information, the practice may deny the request.

If the patient prefers or requests electronic communications, he or she should be reminded that the PHI may not be secure. They should use the Electronic Communication Form to acknowledge the risk involved in this communication format.

Restrictions
Patients may request restrictions on how their PHI may be used. However, covered entities are not required to agree to the requested restriction. Patients may not request restrictions for uses required by law or for workers' compensation purposes. If the provider, using professional judgment, determines that agreeing to the restriction would not be in the best interest of the patient, the request may be denied.

Covered entities are required to grant a request for a restriction disclosure to the patient's health plan for a service or item for which the individual pays for totally out of pocket. This request must be made in writing. Another individual, such as a friend or family member, may pay for the service or item, but the patient cannot have another plan contribute toward the payment.

Inspect and Copy
Patients have the right to access, inspect, or copy routine PHI. However, they do not have the right to access, inspect, or copy notes or records restricted by another law, such as CLIA. The right to access PHI is suspended during participation in clinical trials. The patient usually agrees to this prior to the participation, and access is restored at the end of the trial.

Access may be denied to personal representatives if the provider, using professional judgment, has reason to believe that the access would not be in the patient's best interest, especially if the provider suspects that the patient may be subject to domestic violence, abuse, or neglect, or if the access may in any way endanger the patient or another individual. Access will also be denied to individuals other than the patient if the patient has requested a restriction and that request has been granted. In the case of inmates, access may be denied if it may endanger anyone there or if it might compromise the work of the facility.

We will charge the patient the allowable rate for providing copies in any format.

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