

TIFT REGIONAL MEDICAL CENTER
Allure Plastic and Reconstructive Surgery

I was referred to Dr. Spikes by (name and relation): _____

I saw/learned about Dr. Spikes in (choose all that apply):

Web: _____ www.allureprs.com _____ www.tiftregional.com

 _____ www.surgery.org

 _____ Other _____

Advertising: _____ Yellow Pages

 _____ Other

Other: _____ Article/News _____

 _____ Seminar _____

I have read about or researched my condition/goals in:

Web: _____ www.surgery.org

 _____ www. _____

Other: _____ Books/Magazines _____

 _____ Seminar _____

Please email me appointment reminders and information about specials and promotions. Y N

Email address _____

**TIFT REGIONAL
MEDICAL CENTER**

**CONSENT TO MEDICAL TREATMENT
OR HOSPITAL ADMISSION**

In consideration of medical services and treatment which may be provided to me by Tift County Hospital Authority d/b/a Tift Regional Medical Center (hereinafter "Hospital") and physicians on the medical staff, emergency room physicians, Tifton Pathological Services, P.C., Tifton Radiology, P.C., and Tifton Anesthesia, P.C., (hereinafter "Physician(s)"), Patient does hereby agree and consent as follows:

1. CONSENT AND TREATMENT AUTHORIZATION

Patient (or the undersigned representative acting on behalf of Patient), does hereby consent to and authorize the administration of such tests, examinations, medical or surgical treatments, including those involving anesthetics, which in the opinion of the Physician(s) may be necessary or appropriate. I also consent to the disposal of tissues or parts removed by or in the course of any surgical procedure that may be performed.

In the event that the Hospital or Physician(s) should determine that blood specimens should be provided by Patient for testing purposes in the interest of the safety of those with whom Patient may come in contact, Patient does hereby consent for such blood withdrawal and for the testing thereof, as well as to the release of test information where this is deemed appropriate for the safety of others.

2. RELEASE FROM RESPONSIBILITY FOR PERSONAL EFFECTS

I understand that the Hospital is not liable for loss or damage to Patient's personal property (including, but not limited to hearing aides, dentures, prosthesis, jewelry, or money) unless it is deposited with the Hospital office for safekeeping.

3. AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient authorizes the Hospital and the Physician(s) to release any information, including all medical information and records, financial information or other information which may be deemed confidential and privileged under State or Federal law including any charts, tests, lab reports, psychological or psychiatric conditions, drug abuse or addiction, alcoholism, sickle cell anemia or human immunodeficiency virus (HIV) infection, including acquired immunodeficiency syndrome (AIDS) or tests for HIV: (a) for this admission, to Patient's attending, consulting and referral physician(s), the discharge planning program, or any insurance company or governmental agency to obtain coverage certification or process Patient's claim(s) for benefits which may be utilized in payment for services and treatment rendered by the Hospital and Physician(s); and (b) for this and any prior admission to the Hospital, to Patient's attending, consulting and referral physician(s). I authorize my name to appear in the Hospital Patient Directory. I authorize Hospital and all attending physicians to release to the Social Security Administration, Department of Medical Assistance, their intermediaries or carriers, or to review organizations, any information about me as needed, if applicable, for a Medicare/Medicaid/TRICARE claim, for this admission, including medical information relating to my treatment. If covered under the Medicare or Champus programs, I acknowledge that I have been provided the Medicare/TRICARE Beneficiary letter if applicable, I understand that health care services may be subject to review by review organizations.

4. PAYMENT OF INSURANCE BENEFITS

Patient, by execution of this Consent to Medical Treatment or Hospital Admission, hereby constitutes and appoints as Patient's attorney-in-fact to act in the Patient's name, place and stead: (a) the Tift County Hospital Authority d/b/a Tift Regional Medical Center to make application with any third-party source which might provide benefits for the payment of Patient's Hospital bill or any portion thereof; and (b) Physician(s) to make application with any third-party source which might provide benefits for the payment of Patient's Physician(s) bill or any portion thereof. Patient further authorizes the payment from any third-party source be made directly to the Hospital to be applied toward Patient's Hospital bill or any portion thereof, and directly to Physician(s) to be applied toward such Physician(s) bill or any portion thereof. I authorize the Hospital to check my credit history.

5. PAYMENT FOR SERVICES

In consideration of the services to be supplied by the Hospital and Physician(s), the Patient shall be personally obligated to pay the full amount of the charges for the services rendered and agrees to pay collection expenses and reasonable attorney's fees if this account is referred for collection.

6. AUTHORIZATION FOR RELEASE OF ACCIDENT INFORMATION

Patient authorizes any city, county or agency to release to the Hospital copies of any and all accident or incident reports and statements concerning any accident or incident in which Patient was injured and required treatment in the Hospital.

7. RELEASE FOR LEAVING HOSPITAL WITHOUT TREATMENT OR DISCHARGE AGAINST MEDICAL ADVICE

Patient understands that leaving the Hospital facility without the advice of a physician may constitute serious risk to Patient's life or health. In the event Patient leaves the Hospital without treatment or medical advice, Patient assumes the risks and consequences thereby and hereby releases the Hospital and Physician(s) from all responsibility or liability from any ill effects which may result therefrom.

8. PATIENT UNDERSTANDING OF CONSENT

Patient certifies by execution of this Consent that he/she has read and understands this Consent to Medical Treatment or Hospital Admission and that he/she is legally authorized to execute this Consent to Medical Treatment or Hospital Admission on behalf of the patient.

PATIENT UNDERSTANDS AND ACKNOWLEDGES THAT SOME OR ALL OF THE HEALTH CARE PROFESSIONALS PERFORMING SERVICES IN THIS HOSPITAL ARE INDEPENDENT CONTRACTORS AND ARE NOT HOSPITAL AGENTS OR EMPLOYEES. INDEPENDENT CONTRACTORS ARE RESPONSIBLE FOR THEIR OWN ACTIONS AND THE HOSPITAL SHALL NOT BE LIABLE FOR THE ACTS OR OMISSIONS OF ANY SUCH INDEPENDENT CONTRACTORS. PATIENT IS AWARE THE PRACTICE OF MEDICINE IS NOT AN EXACT SCIENCE AND ACKNOWLEDGES THAT NO GUARANTEES HAVE BEEN MADE TO THE PATIENT AS TO THE RESULTS OF EXAMINATIONS, TESTS, MEDICAL OR SURGICAL TREATMENT OR CARE IN THE HOSPITAL. PATIENT UNDERSTANDS THAT THE HOSPITAL IS A TEACHING HOSPITAL AND OBSERVATION AND PARTICIPATION ARE NECESSARY FOR TEACHING PURPOSES. PATIENT GIVES PERMISSION FOR STUDENTS TO OBSERVE AND PARTICIPATE IN ANY CARE OR PROCEDURE, UNDER PROPER SUPERVISION, DEEMED PROPER IN THE EDUCATION PROCESS.

DATE

SIGNED PATIENT / REPRESENTATIVE

WITNESS
consent5 Rev 10/08/08

RELATIONSHIP TO PATIENT

**INFORMED CONSENT TO
ROUTINE TESTS AND TREATMENTS**

Important: Do not sign this form without reading and understanding its contents.
You may mark out and initial any section
of this form for which consent is not granted.

During the course of my care and treatment at Tift Regional Medical Center (TRMC), I understand that different types of tests and treatments ("Tests" and "Treatments") may be necessary. These Tests and/or Treatments may be performed by physicians, nurses, technicians, physician assistants, or other healthcare professionals licensed under Georgia Law ("Healthcare Professionals").

Medical care is usually safe, however, there are risks associated with each of these Tests and Treatments. I understand that it is not possible to list every risk for every Test or Treatment and that this form only attempts to identify the most common material risks and the most common alternatives.

IF I HAVE ANY QUESTIONS OR CONCERNS REGARDING THESE TESTS OR TREATMENTS, I WILL ASK MY PHYSICIAN TO PROVIDE ME WITH MORE INFORMATION.

I also understand that my physician may ask me to sign another Informed Consent document.

These Tests and/or Treatments may include the following:

- (1) **Needle Sticks:** such as shots, injections, intravenous lines, intravenous injections (IV's), or drawing blood (venipuncture). The material risks associated with Needle Sticks include, but are not limited to, nerve damage, infection, infiltration (which is fluid leakage into surrounding tissue), disfiguring scarring, loss of limb function, paralysis and partial paralysis, or death. Alternatives to Needle Sticks (if available) include oral, rectal, nasal, or topical medications (each of which may be less effective) or refusal of treatment, or there may not be an alternative.
- (2) **Administration of Medications:** whether orally, rectally, through an IV, topically, or through the eye, ear, or nose. The material risks associated with giving medication include allergic reaction, brain damage, or death. Except for possibly changing the route of giving the medication, there is no alternative except refusal of treatment.

I understand that:

- The practice of medicine is not an exact science and that NO GUARANTEES OR ASSURANCES HAVE BEEN MADE to me concerning the outcome and/or result of any Test or Treatment;
- The Healthcare Professionals participating in my care will rely on my documented medical history, as well as other information obtained from me, my family and others having knowledge about me, in determining whether to perform or recommend the Test or Treatment. I agree to provide accurate and complete information about my medical history and conditions; and
- Some or all of the Healthcare Professionals performing services in TRMC are independent contractors and are not Hospital Agents or employees. Independent contractors are responsible for their own actions and TRMC is not liable for the acts or omissions of any such independent contractors.

By signing this form:

- I consent to Healthcare Professionals performing Tests and/or Treatments as they may deem necessary in their professional judgment, including those that may be unforeseen or not known to be needed at the time this consent is obtained; and
- I have been informed in terms I understand the nature and purpose of the Tests and/or Treatments the material risks and practical alternatives.

Signature of Patient (or person giving Consent)

Relationship

Date

Patient unable to sign because:

Witness

Date

**TIFT REGIONAL
MEDICAL CENTER**

**ACKNOWLEDGEMENT OF JOINT NOTICE
OF PRIVACY PRACTICES**
For All Patients

Patient acknowledges receipt of a copy of Tift Regional Medical Center's Joint Notice of Privacy Practices.

Date

Patient / Representative Signature

Witness

Relationship to Patient

Indicate one of the following with an "X" if acknowledgment is not signed.

Notice previously received and acknowledged.

Patient refused to sign.

Patient refused copy of notice.

Other _____

Date _____

Employee Signature _____

JOINT 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 PURSUANT TO FEDERAL REGULATIONS. PLEASE REVIEW IT CAREFULLY.

At Tift Regional Medical Center ("TRMC"), we understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive at the hospital. We need this record to provide you with quality care and to comply with certain legal requirements. This Joint Notice ("Notice") applies to all of the records of your care generated by TRMC, whether made by TRMC personnel or your personal physicians and allied health practitioners.

This Notice will tell you about the ways in which TRMC may use and disclose medical information about you, referred to below as protected health information ("PHI"). This Notice also describes your rights and certain obligations TRMC has regarding the use and disclosure of PHI. This Notice describes TRMC's practices and that of: all physicians and health care practitioners who are members of TRMC's medical staff and have clinical privileges; any health care practitioner authorized to enter information into your hospital chart; all departments, units or clinics of TRMC, whether located on the hospital campus or at other locations; any member of a volunteer group we allow to help you while you are in the hospital; all employees, staff and other TRMC personnel. All these persons, entities, sites and locations may share PHI with each other for treatment, payment or operations as described in this Notice.

Physicians and TRMC. TRMC and physicians who provide health care services in the hospital or hospital-owned locations are separate legal entities and with limited exceptions, the physicians are not employees of TRMC. The physicians may have different policies or notices regarding their use and disclosure of your medical information created in their offices or clinics and are responsible for their own compliance with privacy regulations.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION

ABOUT YOU. TRMC may use or disclose your PHI for the purposes described in more detail below, without obtaining written authorization from you. In addition, TRMC and the members of its medical and allied health professional staff who participate in the organized health care arrangement described below may share your PHI with each other as necessary to carry out their treatment, payment and health care operations related to the organized health care arrangement.

For Treatment. TRMC may use and disclose PHI in the course of providing, coordinating, or managing your medical treatment, including the disclosure of PHI for treatment activities of another health care provider. These types of uses and disclosures may take place between physicians, nurses, technicians, students, and other health care professionals who provide you health care services or are otherwise involved in your care. For example, if you are being treated by a primary care physician, that physician may need to use/disclose PHI to a specialist physician whom he or she consults regarding your condition, or to a nurse who is assisting in your care. TRMC may also disclose PHI about you to people outside the hospital, such as family members, clergy or others who provide services that are part of your care.

For Payment. TRMC may use and disclose PHI in order to bill and collect payment for the health care services provided to you. For example, TRMC may need to give PHI to your health plan in order to be reimbursed for the services provided to you. TRMC may also disclose PHI to its business associates, such as billing companies, claims processing companies, and others that assist in processing health claims. TRMC may also disclose PHI to other health care providers and health plans for the payment activities of such providers or health plans.

For Health Care Operations. TRMC may use and disclose PHI as part of its operations, including for quality assessment and improvement, such as evaluating the treatment and services you receive and the performance of staff and physicians in caring for you, patient surveys, provider

training, underwriting activities, compliance and risk management activities, planning and development, and management and administration. TRMC may disclose PHI to doctors, nurses, technicians, students, attorneys, consultants, accountants, and others for review and learning purposes, to help make sure TRMC is complying with all applicable laws, and to help TRMC continue to provide quality health care to its patients. TRMC may also disclose PHI to other health care providers and health plans for such entity's quality assessment and improvement activities, credentialing and peer review activities, and health care fraud and abuse detection or compliance, provided that such entity has, or has had in the past, a relationship with the patient who is the subject of the information.

For Sharing PHI Among TRMC And Its Medical Staff. TRMC and the physicians and other health care providers who are members of the TRMC medical staff work together in an organized health care arrangement to provide medical services to you when you are a patient at TRMC. TRMC and the medical staff members will share PHI that they collect from you at TRMC with each other as necessary to carry out their treatment, payment and health care operations relating to the provision of care to patients at TRMC.

As Required by Law and Law Enforcement. TRMC may use or disclose PHI when required to do so by applicable law and when ordered to do so in a judicial or administrative proceeding. TRMC may also use or disclose PHI to identify or locate a suspect, fugitive, material witness, or missing person, when dealing with gunshot and other wounds, about criminal conduct, to report a crime, the location of the crime or victims, or the identity, description, or location of a person who committed a crime, or for other law enforcement purposes.

For Public Health Activities and Public Health Risks. TRMC may disclose PHI to government officials in charge of collecting information about births and deaths, preventing and controlling disease, reports of child abuse or neglect and of other victims of abuse, neglect, or domestic violence, reactions to medications or product defects or problems, or to notify a person who may have been exposed to a communicable disease or may be at risk of contracting or spreading a disease or condition.

For Health Oversight Activities. TRMC may disclose PHI to the government for oversight activities authorized by law, such as audits, investigations, inspections, licensure or disciplinary actions, and other proceedings, actions or activities necessary for monitoring the health care system, government programs, and compliance with civil rights laws.

Coroners, Medical Examiners, and Funeral Directors. TRMC may disclose PHI to coroners, medical examiners, and funeral directors for the purpose of identifying a decedent, determining a cause of death, or otherwise as necessary to enable these parties to carry out their duties consistent with applicable law.

Organ, Eye, and Tissue Donation. TRMC may release PHI to organ procurement organizations to facilitate organ, eye, and tissue donation and transplantation.

Research. Under certain circumstances, TRMC may use and disclose PHI for medical research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another, for the same condition.

To Avoid a Serious Threat to Health or Safety. TRMC may use and disclose PHI, to law enforcement personnel or other appropriate persons, to prevent or lessen a serious threat to the health or safety of a person or the public.

Specialized Government Functions. TRMC may use and disclose PHI of military personnel and veterans under certain circumstances. TRMC may also disclose PHI to authorized federal officials for intelligence, counter intelligence, and other national security activities, and for the provision of

protective services to the President or other authorized persons or foreign heads of state or to conduct special investigations.

Workers' Compensation. TRMC may disclose PHI to comply with workers' compensation or other similar laws. These programs provide benefits for work-related injuries or illnesses.

Fundraising Activities. Your PHI may be used to contact you in an effort to raise money for TRMC. Your PHI may be disclosed to a foundation related to TRMC. Such disclosure would be limited to contact information, such as your name, address and phone number and the dates you required treatment or services at TRMC. If you do not want to be contacted as part of these fundraising activities, please notify the Marketing Department in writing.

Inmates. If you are an inmate in a correctional institution or under the custody of a law enforcement official, TRMC may release PHI about you to the correctional institution or law enforcement official for treatment, payment, or for protection of the health and safety of you or others or for the safety and security of the correctional institution.

Appointment Reminders; Health-related Benefits and Services; Marketing. TRMC may use and disclose your PHI to contact you and remind you of an appointment at TRMC, or to inform you of treatment alternatives or other health-related benefits and services that may be of interest to you, such as disease management programs. TRMC may use and disclose your PHI to encourage you to purchase or use a product or service through a face-to-face communication or by giving you a promotional gift of nominal value.

Disclosures to You or for HIPAA Compliance Investigations. TRMC may disclose your PHI to you or to your personal representative, and is required to do so in certain circumstances described below in connection with your rights of access to your PHI and to an accounting of certain disclosures of your PHI. TRMC must disclose your PHI to the Secretary of the United States Department of Health and Human Services (the "Secretary") when requested by the Secretary in order to investigate TRMC's compliance with privacy regulations issued under the federal Health Insurance Portability and Accountability Act of 1996.

Patient Directories. Unless you object, TRMC may use some of your PHI to maintain a directory of individuals in its facility. This information may include your name, your location in the facility, your general condition (e.g. fair, stable, etc.), and your religious affiliation, and the information may be disclosed to members of the clergy. Except for your religious affiliation, the information may be disclosed to other persons who ask for you by name.

Disclosures to Individuals Involved in Your Health Care or Payment for Your Health Care. Unless you object, TRMC may disclose your PHI to a family member, other relative, friend, or other person you identify as involved in your health care or payment for your health care. TRMC may also notify these people about your location or condition. In addition, TRMC may disclose PHI about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

OTHER USES AND DISCLOSURES. Other types of uses and disclosures of your PHI not described above will be made only with your written authorization, which with some limitations, you have the right to revoke in writing. If you revoke your permission, TRMC will no longer use or disclose PHI about you for the reasons covered in your written authorization. You understand that TRMC is unable to take back any disclosures already made with your permission, and that TRMC is required to retain records of the care provided to you.

REGULATORY REQUIREMENTS. TRMC is required by law to maintain the privacy of your PHI, to provide individuals with notice of TRMC's legal duties and privacy practices with respect to PHI, and to abide by the terms described in the Notice currently in effect. We will post a copy of the current Notice in the hospital.

RIGHTS. You have the following rights regarding your PHI:

Restrictions. You may request that TRMC restrict the use and disclosure of your PHI. For example, you could ask that we not use or disclose information about a surgery you had. To request restrictions, you must make your request in writing to the Health Information Management Department. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the restrictions to apply, for example, disclosures to your spouse.

Alternative Communications. You have the right to request that communications of PHI to you from TRMC be made by particular means or at particular locations. For instance, you might request that communications be made at your work address, instead of your home address. Your requests must be made in writing and sent to the Privacy Officer. TRMC will accommodate your reasonable requests without requiring you to provide a reason for your request.

Inspect and Copy. Generally, you have the right to inspect and copy your PHI that TRMC maintains, provided that you make your request in writing to the Health Information Management Department. If you request copies of your PHI, we may impose a reasonable fee to cover copying and postage. If we deny access to your PHI, we will explain the basis for denial and your opportunity to have your request and the denial reviewed by a licensed health care professional (who was not involved in the initial denial decision) designated as a reviewing official. If TRMC does not maintain the PHI you request and if we know where that PHI is located, we will tell you how to redirect your request.

Amendment. If you believe that your PHI maintained by TRMC is incorrect or incomplete, you may ask us to correct your PHI. Your request must be made in writing to the Health Information Management Department, and it must explain why you are requesting an amendment to your PHI. We generally can deny your request if your request relates to PHI: (i) not created by TRMC; (ii) not part of the records TRMC maintains; (iii) not subject to being inspected by you; or (iv) that is accurate and complete. If your request is denied, we will provide you a written denial that explains the reason for the denial and your rights to: (i) file a statement disagreeing with the denial; (ii) if you do not file a statement of disagreement, submit a request that any future disclosures of the relevant PHI be made with a copy of your request and TRMC's denial attached; and (iii) complain about the denial.

Accounting of Disclosures. You generally have the right to request and receive a list of the disclosures of your PHI we have made at any time during the six (6) years prior to the date of your request (provided that such a list would not include disclosures made prior to April 14, 2003). The list will not include disclosures made at your request, with your authorization, and does not include certain uses and disclosures to which this Notice already applies, such as those: (i) for treatment, payment, and health care operations; (ii) made to you; (iii) for TRMC's patient directory or to persons involved in your health care; (iv) for national security or intelligence purposes; or (v) to correctional institutions or law enforcement officials. You should submit any such request to the Health Information Management Department. TRMC will provide the list to you at no charge, but if you make more than one request in a year you will be charged a fee of the costs of providing the list.

Right to Copy of Notice. You have the right to receive a paper copy of this notice upon request. You can receive a copy of this notice at our Web site, www.tifregional.com. To obtain a paper copy of this notice, please contact the Privacy Officer at (229) 353-7553.

Right to File A Complaint. You may complain to TRMC if you believe your privacy rights with respect to your PHI have been violated by contacting the Privacy Officer, P.O. Box 747, Tifton, GA 31793, (229) 353-7553 and submitting a written complaint. You also have the right to file a complaint with the Secretary of the Department of Health and Human Services. You will not be penalized for filing a complaint.

Contact the Privacy Officer, P.O. Box 747, Tifton, GA 31793 (229) 353-7553 if you have questions about this Notice.