

CONSENT TO ROUTINE PROCEDURES AND TREATMENTS

Important: Do not sign this form without reading and understanding its contents.

I hereby apply for and consent to admission and treatment by this Hospital and its Medical Staff, and authorize all routine hospital activities, treatments, examinations, and diagnostic services. During the course of my care and treatment, I understand that various types of tests and diagnostic treatment procedures ("Procedures") may be necessary. These Procedures may be performed by physicians, nurses, technicians, physician assistants or other healthcare professionals ("Healthcare Professionals"). While routinely performed without incident, there may be material risks associated with each of these Procedures. I understand that is not possible to list every risk for every Procedure and that this form only attempts to identify the most common material risks and the alternatives (if any) associated with the Procedures. I also understand that various Healthcare Professionals may have differing opinions as to what constitutes material risks and alternative Procedures.

The Procedures may include, but are not limited to the following:

- (1) **Needle Sticks**, such as shots, injections, intravenous lines, or intravenous injections (IVs). The material risks associated with these types of Procedures include, but are not limited to, nerve damage, infection, infiltration (which is fluid leakage into surrounding tissue), disfiguring scar, loss of limb function, paralysis or 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.
- (2) **Physical tests, assessments and treatments** such as vital signs, internal body examinations, wound cleansing, wound dressing, range of motion checks, and other similar procedures. The material risks associated with these types of Procedures include, but are not limited to, allergic reactions, infection, severe loss of blood, muscular-skeletal or internal injuries, nerve damage, loss of limb function, paralysis or partial paralysis, disfiguring scar, worsening of the condition and death. Apart from using modified Procedures and/or refusal of treatment, no practical alternatives exist.
- (3) **Administration of Medications** whether orally, rectally, topically or through the eye, ear or nose. The material risks associated with these types of Procedures include, but are not limited to, perforation, puncture, infection, allergic reaction, brain damage or death. Apart from varying the method of administration and/or refusal of treatment, no practical alternatives exist.
- (4) **Drawing Blood, Bodily Fluids or Tissue Samples** such as those done for laboratory testing and analysis. The material risks associated with this type of Procedure include, but are not limited to, paralysis or partial paralysis, nerve damage, infection, bleeding and loss of limb function. Apart from long-term observation and/or refusal of treatment, no practical alternatives exist.
- (5) **Insertion of Internal Tube** such as bladder catheterizations, nasogastric tubes, rectal tubes, drainage tubes, enemas, etc. The material risks associated with these types of Procedures include, but are not limited to, internal injuries, bleeding, infection, allergic reaction, loss of bladder control and/or difficulty urinating after catheter removal. Apart from external collection devices or refusal of treatment, no practical alternatives exist.



CONSENT TO ROUTINE PROCEDURES AND TREATMENTS

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 Procedures;
- The Healthcare Professionals participating in my care will rely on my documented medical history, as well as other information obtained from me, my family or others having knowledge about me, in determining whether to perform or recommend the Procedures; therefore, I agree to provide accurate and complete information about my medical history and conditions;
- The physicians, dentists, oral surgeons, podiatrists and psychologists at Gwinnett Hospital System are independent contractors of the Hospital and are not its employees or agents. As independent contractors, the physicians, dentists, oral surgeons, podiatrists and psychologists are responsible for their own actions; and
- I may withdraw my consent for **any** test or procedure at **any** time.

By signing this form:

- I consent to Healthcare Professionals performing Procedures as they may deem reasonably necessary or desirable in the exercise of their professional judgment, **including those Procedures that may be unforeseen or not known to be needed at the time this consent is obtained;**
- I acknowledge that I have been informed in general terms of the nature and purpose of the Procedures; the material risks of the Procedures; and practical alternatives to the Procedures.
- I consent to the observation and participation of personnel-in-training and students in my care and treatment.
- I consent to the disposal by hospital authorities of any specimens, tissue or parts that may be removed from my body during my hospitalization.

If you have a different request for the handling of any of these specimens, tissues, or parts please speak to your nurse. For disposition of fetal remains use Attachment E of Policy 7009-02 Fetal Death. For all other tissues please use the GHS Request and Authorization form for release. See Attachment F of Policy 7009-02.

- **If I have any questions or concerns regarding these Procedures, I will ask my physician to provide me with additional information.** I also understand that my physician may ask me to sign additional Informed Consent documents.

Patient/Patient's Representative

Date

Relationship if other than self

Reason Patient is unable to sign (if applicable)

Witness

Date

For Gwinnett Hospital Use Only:	
INTERPRETIVE SERVICE USED ON THIS ENCOUNTER	
Interpreter used - Name or Number _____	
Date/Time _____	Language _____

CONTRACT FOR CONTROLLED SUBSTANCE PRESCRIPTIONS

Controlled substance medications (i.e., narcotics, tranquilizers, and barbiturates) are very useful, but have a high potential for misuse. Therefore, the local state and federal government closely control them. These medications are intended to relieve pain and improve function.

I agree to the following conditions regarding the medication my provider is prescribing for managing pain, anxiety, or insomnia:

1. I am responsible for my controlled substance medications. If the prescription is lost, misplaced, stolen, or if I use it all sooner than prescribed, I understand that it will not be replaced.
2. I will not request or accept controlled substance medication from any other physician or individual while I am receiving such medication from Dr. Stechison.
3. Refills of controlled substance medication:
 - Will only be made during regular office hours, in person, and once each month during a scheduled office visit. There will be no refills at night, holidays, or weekends.
 - Will not be made if I "run out early." I am responsible for taking the medication in the dose prescribed, and for keeping track of the remaining amount.
 - Will not be made as an "emergency" (i.e., refills will not be made on Friday afternoon because I suddenly realize I will run out tomorrow). I will call at least 24 hours ahead if I need assistance with a controlled substance medication prescription.
4. I understand that if I violate any of the above conditions, my controlled substance prescriptions with Dr. Stechison, may be ended immediately. I may also be released from his/her care.
5. I understand that the main treatment goal is to relieve my pain and improve my ability to function. In consideration of that goal, and the fact that I am being given potent medicine to help me reach that goal, I agree to help myself by following better health habits. I understand that only through following a healthier lifestyle, can I hope to have the most successful outcome of my treatment.

I have been fully informed by Dr. Stechison, and his staff regarding potential dependence (addiction) to a controlled substance. I understand this is rare. However, I know that some people may develop a tolerance, which is the need to increase the dose of the medication to achieve the same effect of pain control. When I stop the medication, I must do so slowly and under medical supervision, or I may have withdrawal symptoms.

I have read this contract, and it has been explained to me. In addition, I fully understand the consequences of violating said contract.

Patient's Signature

Witness

Date

GHS 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.

For the purposes of this Notice of Privacy Practices (“Notice”), Gwinnett Hospital System, Inc. (The “Hospital”) and the physicians and other health care providers who are members of the Hospital’s medical staff (the “Medical Staff”) work together in an organized health care arrangement to provide medical services to you when you are a patient in one of the Hospital’s inpatient facilities (including Gwinnett Medical Center, Joan Glancy Memorial Hospital) or outpatient diagnostic and treatment facilities or clinics. However, physicians and other health care providers who are members of the Medical Staff are engaged in the independent practice of medicine and are not employees or agents of the Hospital. The Hospital and the Medical Staff are referred to collectively in this Notice as “GHS.” As health care providers, the GHS providers use confidential personal health information about patients, referred to below as protected health information (“PHI”). GHS protects the privacy of this information, and it is also protected from disclosure by state and federal law. In certain specific circumstances, pursuant to this Notice, patient authorization or applicable laws and regulations, PHI can be used by GHS or disclosed to other parties. Below are categories describing these uses and disclosures, along with some examples to help you better understand each category.

Uses and Disclosures for Treatment, Payment and Health Care Operations. GHS may use or disclose your PHI for the purposes of treatment, payment and health care operations, described in more detail below, without obtaining written authorization from you. In addition, the GHS providers may share your PHI as necessary to carry out its treatment, payment and health care operations related to the organized health care arrangement.

For Treatment. GHS 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.

For Payment. GHS may use and disclose PHI in order to bill and collect payment for the health care services provided to you. For example, GHS may need to give PHI to your health plan in order to be reimbursed for the services provided to you. GHS may also disclose PHI to its business associates, such as billing companies, claims processing companies, and others that assist in processing health claims. GHS 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. GHS 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 its staff in caring for you, provider training, underwriting activities, compliance and risk management activities, planning and development, and management and administration. GHS may disclose PHI to doctors, nurses, technicians, students, attorneys, consultants, accountants, and others for review and learning purposes, to help make sure GHS is complying with all applicable laws, and to help GHS continue to provide health care to its patients at a high level of quality. GHS 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.

Sharing of PHI Among the Hospital and the Medical Staff. As an organized health care arrangement, the Hospital and the members of the Medical Staff will share with each other PHI that they collect from you as necessary to carry out their treatment, payment and health care operations relating to the provision of care to patients by GHS.

Other Uses and Disclosures For Which Authorization is Not Required. In addition to using or disclosing PHI for treatment, payment and health care operations, GHS may use and disclose PHI without your written authorization under the following circumstances:

As Required by Law and Law Enforcement. GHS may use or disclose PHI when required to do so by applicable law. GHS also may disclose PHI when ordered to do so in a judicial or administrative proceeding, 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, to report a death or injury resulting from a boating accident, or for other law enforcement purposes.

For Public Health Activities and Public Health Risks. GHS 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. GHS 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. GHS 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. GHS may release PHI to organ procurement organizations to facilitate organ, eye, and tissue donation and transplantation.

Research. Under certain circumstances, GHS may use and disclose PHI for medical research purposes.

To Avoid a Serious Threat to Health or Safety. GHS 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. GHS may use and disclose PHI of military personnel and veterans under certain circumstances. GHS may also disclose PHI to authorized federal officials for intelligence, counterintelligence, 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. GHS 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 the Hospital. Your PHI may be disclosed to a foundation related to the Hospital. 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 the Hospital. The money

raised in connection with these activities would be used to expand and support the Hospital's provision of health care and related services to the community. If you do not want to be contacted as part of these fundraising activities, please notify the Gwinnett Hospital System Foundation in writing.

Appointment Reminders; Health-related Benefits and Services; Marketing. GHS may use and disclose your PHI to contact you and remind you of an appointment at GHS, 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. GHS 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. GHS 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. GHS 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 GHS' compliance with privacy regulations issued under the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

Uses and Disclosures To Which You Have an Opportunity to Object. You will have the opportunity to object to these categories of uses and disclosures of PHI that GHS may make:

Patient Directories. Unless you object, GHS 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, GHS 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. GHS may also notify those people about your location or condition.

Other Uses and Disclosures of PHI For Which Authorization is Required. 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.

Regulatory Requirements. GHS is required by law to maintain the privacy of your PHI, to provide individuals with notice of its legal duties and privacy practices with respect to PHI, and to abide by the terms described in this Notice. GHS reserves the right to change the terms of this Notice and of its privacy policies, and to make the new terms applicable to all of the PHI it maintains. Before GHS makes an important change to its privacy policies, it will promptly revise this Notice and post a new Notice in all patient entry locations. You have the following rights regarding your PHI:

You may request that GHS restrict the use and disclosure of your PHI. GHS is not required to agree to any restrictions you request, but if GHS does so it will be bound by the restrictions to which it agrees except in emergency situations.

You have the right to request that communications of PHI to you from GHS be made by particular means or at particular locations. For instance, you might request that communications be made at your work address, or by e-mail rather than regular mail. Your request must be made in writing and sent to the Privacy Officer. GHS will accommodate your reasonable requests without requiring you to provide a reason for your request.

Generally, you have the right to inspect and copy your PHI that GHS maintains, provided that you make your request in writing to the

Hospital's Department of Medical Records. Within thirty (30) days of receiving your request (unless extended by an additional thirty (30) days), GHS will inform you of the extent to which your request has or has not been granted. In some cases, GHS may provide you a summary of the PHI you request if you agree in advance to such a summary and any associated fees. If you request copies of your PHI or agree to a summary of your PHI, GHS may impose a reasonable fee to cover copying, postage, and related costs. If GHS denies access to your PHI, it 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 GHS does not maintain the PHI you request, if it knows where that PHI is located it will tell you how to redirect your request.

If you believe that your PHI maintained by GHS contains an error or needs to be updated, you have the right to request that GHS correct or supplement your PHI. Your request must be made in writing to the Hospital's Department of Medical Records, and it must explain why you are requesting an amendment to your PHI. Within sixty (60) days of receiving your request (unless extended by an additional thirty (30) days), GHS will inform you of the extent to which your request has or has not been granted. GHS generally can deny your request if your request relates to PHI: (i) not created by GHS; (ii) that is not part of the records GHS maintains; (iii) that is not subject to being inspected by you; or (iv) that is accurate and complete. If your request is denied, GHS 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 GHS's denial attached; and (iii) complain about the denial. You generally have the right to request and receive a list of the disclosures of your PHI that GHS has 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 disclosure for which you have provided a written 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 the Hospital'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 Hospital's Department of Medical Records, and within sixty (60) days of receiving your request (unless extended by an additional thirty (30) days), GHS will respond to you regarding the status of your request. GHS will provide the list to you at no charge, but if you make more than one request in a year you may be charged a fee for each additional request. You have the right to receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically. You can receive a copy of this Notice at our Web site, <http://www.gwinnetthealth.org>. To obtain a paper copy of this Notice, please contact the GHS Privacy Officer.

You may complain to GHS if you believe your privacy rights with respect to your PHI have been violated by contacting a Hospital Patient Representative or the GHS Privacy Officer and submitting a written complaint. GHS will in no manner penalize you or retaliate against you for filing a complaint regarding GHS' privacy practices. You also have the right to file a complaint with the Secretary of the Department of Health and Human Services.

If you have any questions about this Notice, please contact the GHS Privacy Officer by mail at 1000 Medical Center Boulevard, Lawrenceville, Georgia 30045, by telephone at (678) 312-3900 or by email at ghsprivacyofficer@gwinnettmedicalcenter.org.

If you have any questions about your medical records, please contact the Medical Records Department by mail at 1000 Medical Center Boulevard, attn Medical Records, Lawrenceville, GA 30045, or by telephone at (678)-312-4490.

Effective Date: April 14, 2003.



FORM 2-18967 REV. 05/2007

**ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES**

I hereby acknowledge that I have received a copy of the Gwinnett Hospital System's Notice of Privacy Practices.

Signature of Patient or Patient's Authorized Representative

Print Name of Patient

Date

As the Patient's Authorized Representative, my relationship with the patient is:

The Patient is unable to sign because:

----- OR -----

CERTIFICATION OF GOOD FAITH EFFORTS TO OBTAIN ACKNOWLEDGMENT

_____ I hereby certify that, as an associate or agent of Gwinnett Hospital System, I have made a good faith effort to obtain from the patient or the patient's authorized representative a written acknowledgment of the Gwinnett Hospital System's Notice of Privacy Practices in accordance with Gwinnett Hospital System's Administration policy (#100-105), "Notice of Privacy Practice Requirements."

Print Name of Associate/Agent, Position and Department

Signature of Associate/Agent

Date

Reason(s) for not obtaining acknowledgment:

_____ Patient's medical condition (critical, unconscious, etc.)

_____ Language barrier

_____ Patient refuses to sign (reason stated: _____)

For Gwinnett Hospital Use Only:

INTERPRETIVE SERVICE USED ON THIS ENCOUNTER

Interpreter used - Name or

Number _____

Date/Time _____ Language



Office Policy

We are happy to complete any paperwork for our patients however there is a fee for this and we should receive this **payment in advance**. Please bring the forms well in advance of their return date, as our staff will need at least **3 business days** to complete the forms and obtain the doctor's signature. If your attorney is requesting any patient information please make sure that you have signed a medical release form either with them or our office. We will inform your attorney's office about our medical records and form fee as well. Medical Records fee will be applied when the patient is not the one receiving or picking up the records.

Disability Forms	\$25.00
Letters	\$25.00
Copy of Medical Records	\$25.00 + (.65 per page)
Handicap Form	\$10.00