Blood & Marrow Transplant Group of Georgia
Patient Demographic Form

Please complete entire form---Do not leave any blanks

BLOOD MARROW TRANSPLANT GROUP OF GEORGIA
DEMOGRAPHIC FORM

□H. Kent Holland, MD □Lawrence Morris, MD □Scott Solomon, MD □Asad Bashey, MD □Melhem Solh, MD
(Please check your consulting physician)

PLEASE FILL OUT FRONT AND BACK OF THIS FORM
PLEASE COMPLETE ENTIRE FORM---DO NOT LEAVE ANY BLANK

Today's Date: ________________

Name (as it appears on license)____ Date of Birth: _____________

SSN ___________________________ Marital Status (please circle): **M S D W** Preferred Language: ___________________

Race: □ American Indian/Alaska Native □ Asian □ Black/African American

□ Native Hawaiian/Other Pacific Islander □ White □ Unknown

Ethnicity: □ Hispanic or Latino □ Not Hispanic or Latino □ Patient Declined

Permanent Address: ____ County:________________________

____

Local Address During Treatment: ____

____

Main Phone Number _______________ Home or Cell (please circle) Alternate Phone Number:_________________________

Permission to leave message on Voice Mail: Y or N (please circle) Email Address:_____________________________________

Emergency Contact Name: ___________________________________ Relation: _______________________________

Emergency Contact Main Phone Number: ___________________________ Secondary Phone Number:_________________

Employer Information: Employer: ____ Status (circle): F/T P/T STD/LTD FMLA

Employer Address: ____

Work Phone:________________________________ HR Contact: ____

Retired: (circle one) **YES NO** Date of Retirement: _______________ Income Status: □ Retired with a source of income
□ Retired without a source of income

Have you ever applied for Medicare Disability? **YES NO** Type: **STD LTD** Date of Application: ________ Eff. Date: ________

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Blood & Marrow Transplant Group of Georgia
Patient Demographic Form

*****Please complete entire form---Do not leave any blanks*****

Physician Information

Referring MD Name: ______________________ Primary Care Name: ______________________

Referring MD Number: ______________________ Primary Care Number: ______________________

Caregiver Information

1. Name: ______________________ Relation: ______________________

   Home Phone Number: ______________________ Cell Phone Number: ______________________

2. Name: ______________________ Relation: ______________________

   Home Phone Number: ______________________ Cell Phone Number: ______________________

Pharmacy Information

Name: ______________________ Phone: ______________________

Primary Insurance Information

Insurance: ______________________ Insurance Phone #: ______________________

Subscriber: (please circle) **Self Spouse Child** Name if different than patient: ______________ DOB: __________

Employer Name & Number (If different than patient): ______________________

I.D. #: ______________________ Group#: ______________________

Secondary Insurance Information

Subscriber: ______________________ Relationship to Patient __________ DOB ________

Employer Name & Number (If different than patient): ______________________

Insurance: ______________________ Insurance Phone #: ______________________

I.D. #: ______________________ Group#: ______________________

Patient Signature: ______________________ **Date:** ______________

Required Form Completion Checked by (staff member only): ______________________ Date: ______________

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Blood and Marrow Transplant Program
at Northside Hospital
Atlanta, Georgia 30342

PATIENT QUESTIONNAIRE

Name: ______________________ **DOB:** ________ **DATE:** ________

Ht: ________ **Wt.:** ________

HOW WOULD YOU RATE YOUR GENERAL HEALTH: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

PERSONAL/PAST MEDICAL HISTORY:

History of the following:	Yes	No	Comments
Asthma			
Pneumonia			
Tuberculosis			
Diabetes			
Heart Disease			
Hypertension			
Kidney Disease			
Liver Disease			
Thyroid Disease			
Arthritis			
Skin Disease			
Nervous Disorder			
Strokes			
Seizures			
CRS/Neurological Toxicity			
Venereal Disease			
Exposure to Hazardous Chemicals			

Additional Personal/Past Medical History:	Yes	No	Diagnosis Date	Comments
History of Herpes Zoster (Shingles)			/ /	
History of DVTs or Blood Clots			/ /	
Pneumothorax				
Myocardial Infarction			/ /	
CABG			/ /	
Stent placement			/ /	
Cardiomyopathy with EF <40%			/ /	
Valve replacement or repair			/ /	
Multiple Sclerosis				
Myasthenia Gravis				
Muscular Dystrophy				
Paraplegia/Quadriplegia				
History of major organ transplant or awaiting transplant			/ /	
Home Oxygen Use			/ /	
Sleep Apnea with or without CPAP			/ /	
History of Difficult Intubations or problems with anesthesia			/ /	

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Have you ever tested positive for Hepatitis B, Hepatitis C, HIV or HTLV? ☐ Yes ☐ No

Do you or a close relative (brother, sister, mother, father, aunt, uncle, grandparent) have an inherited condition (such as sickle cell disease or trait, thalassemia, SC disease, genetic disorder, cystic fibrosis, etc.)? ☐ No ☐ **Yes**—*Complete the following information*:

Inherited Condition	Treatment	Relationship to You

Do you have a hematological disease (for example, hemophilia) or immunological disease (lupus, crohn's disease, rheumatoid arthritis, etc.)? ☐ No ☐ **Yes**—*Complete the following information*:

Disease	Year of Diagnosis	Treatment

Have you ever been treated for a malignant disease (Cancer)? ☐ No ☐ **Yes**—*Specify below:*

Type of Cancer	Diagnosis Date	Treatment Dates (include any prior transplants)

During previous hospitalizations, have you ever been placed on "CONTACT PRECAUTIONS" or "ISOLATION"? ☐ No ☐ **Yes**—*Specify the reason(s) why below:*

☐ VRE ☐ MRSA ☐ Don't Know ☐ Other Reason: ____________________

List Any Other Illnesses, Injuries, and/or Surgeries:

Name of Illness, Injury, and/or Surgery	Year	Complications?

Dental Assessment:

When was your last dental exam? ____________ Condition of Oral Cavity: ____________________

Please complete the following:

Childhood Illnesses	Yes	No	Year
Measles			
Mumps			
Chicken pox			
Polio			
Rheumatic Fever			
Other:			

Immunizations	Yes	No	Year
Small Pox			
Tetanus			
Polio			
Hepatitis			
MMR			

Transfusion History:

Have you ever received a Red Blood Cell (RBC) transfusion? ☐ **No** ☐ **Yes**—*Specify below:*

Did you experience a transfusion reaction? ☐ Yes ☐ No Require pre-medications? ☐ Yes ☐ No

Have you ever received a platelet transfusion? ☐ **No** ☐ **Yes**—*Specify below:*

Did you experience a transfusion reaction? ☐ Yes ☐ No Require pre-medications? ☐ Yes ☐ No

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Allergy History: *List all drugs, foods, tapes, latex, or substances (including albumin), to which you are allergic and specify the type of reaction you experience (e.g. itching, rash, wheezing, swelling, etc.)*

Allergy	Reaction

FAMILY HISTORY:

History of the following:	Yes*	No	*If Yes, Relative(s)	Comments
Asthma				
Pneumonia				
Tuberculosis				
Diabetes				
Heart Disease				
Hypertension				
Kidney Disease				
Liver Disease				
Thyroid Disease				
Arthritis				
Skin Disease				
Nervous Disorder				
Strokes				
Seizures				
Venereal Disease				

FAMILY CURRENT STATUS:

Family Member	Age	State of Health
Father		
Mother		
Siblings: (include names)		
Children: (include names)		

Number of people living in your household: ________________

Number of people <u>under the age of 18</u> currently living in your household: ______________

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Blood and Marrow Transplant Program
at Northside Hospital
Atlanta, Georgia 30342

Social History:

Where were you born? *(City, State or Country)*: ______________________

What is your ethnicity? ☐ Hispanic or Latino ☐ Not Hispanic or Latino

What is your Race? *Check all that apply:*

White	Black or African American	American Indian or Alaska Native	Asian	Native Hawaiian / Other Pacific Islander	Decline
☐ Eastern European	☐ African	☐ Alaskan Native or Aleut	☐ South Asian	☐ Guamanian	☐ I decline to provide race
☐ Mediterranean	☐ African American	☐ North American Indian	☐ Filipino (Pilipino)	☐ Hawaiian	
☐ Middle Eastern	☐ Black Caribbean	☐ American Indian, South or Central America	☐ Japanese	☐ Samoan	
☐ North Coast of Africa	☐ Black South or Central American	☐ Caribbean Indian	☐ Korean	☐ Other Pacific Islander	
☐ North American	☐ Other Black		☐ Chinese		
☐ Northern European			☐ Vietnamese		
☐ Western European			☐ Other Southeast Asian		
☐ White Caribbean					
☐ White South or Central American					
☐ Other White					

Marital status: ☐ Single (never married) ☐ Married/living with partner ☐ Separated ☐ Divorced ☐ Widowed

What is the highest educational grade or degree you've completed? ______________________

Are you currently in school or were you enrolled in school prior to your illness? ☐ Yes ☐ No

What is your Current / Most Recent Occupation? ______________________
**If not currently employed, list your last job; include any military service (if applicable)*

What is your current (or most recent) work status (within the last year)?

☐ Full Time ☐ Part time *(by choice, not due to illness)* ☐ Part Time *(due to illness)*
☐ Medical Disability ☐ Unemployed *(not due to illness)* ☐ Retired

Hobbies: ______________________

Travel History*: *(Outside of the USA)*: ______________________
**Please list places and dates of travel*

Combined Household gross annual income*:
**Include earnings by all family members living in the household, before taxes*

☐ Less than $20,000 ☐ $20,000-$39,999 ☐ $40,000-$59,999 ☐ $60,000-$79,999
☐ $80,000-$99,999 ☐ $100,000 and over ☐ Decline to answer question

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Habits:

Have you ever smoked cigarettes? ☐ No ☐ Yes; *specify below:*

How many years? _________ Average # of packs of cigarettes per day: _______

Have you smoked cigarettes within the past year? ☐ Yes ☐ No—When did you quit? ________

Have you ever used the following *(check all that apply)*:

☐ **Chewing Tobacco; frequency of use:** ____________________

☐ **Cigars/Pipes; frequency of use:** ____________________

☐ **E-cigarettes/vape; frequency of use:** ____________________

☐ **Marijuana; frequency of use:** ____________________

Do you drink alcohol? ☐ No ☐ Yes; *specify type and frequency:* ________________________

Do you use Recreational Drugs? ☐ No ☐ Yes; *specify type and frequency:* ________________

Do you Exercise? ☐ No ☐ Yes; *specify type and frequency:* ___________________________

Medications:

List all medications you take regularly, including over the counter, herbal supplements, and vitamins

Medication Name	Amount / Dosage and Frequency per day

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REVIEW OF SYSTEMS:

General:	Yes	No	Date of Onset (if unknown, leave blank)	Comments
Weakness			/ /	
Tiredness			/ /	
Pain			/ /	
Appetite changes			/ /	
Weight change			/ /	
Chills			/ /	
Fevers			/ /	
Night Sweats			/ /	
HEENT:				
Visual changes			/ /	
Hearing changes			/ /	
Nosebleeds			/ /	
Sinus problems			/ /	
Hoarseness			/ /	
Neck pain			/ /	
Dental problems			/ /	
Bleeding gums			/ /	
Respiratory:				
Cough			/ /	
Cough up blood			/ /	
Wheezing			/ /	
Shortness of breath at rest			/ /	
Shortness of breath with activity			/ /	
Cardiovascular:				
Chest pain			/ /	
Shortness of breath when lying flat			/ /	
Palpitations (irregular heart beat)			/ /	
Heart murmur			/ /	
Leg swelling			/ /	
Leg pain			/ /	
Blue/purple discoloration hands or feet			/ /	
Breasts:				
Monthly self-breast exam			/ /	
Lumps			/ /	
Pain			/ /	
Nipple discharge			/ /	
Gastrointestinal:				
Nausea			/ /	
Vomiting			/ /	
Diarrhea			/ /	
Constipation			/ /	
Change in bowel pattern			/ /	
Heart burn			/ /	
Abdominal pain			/ /	
Bright red blood in stools			/ /	
Black stools			/ /	
Hemorrhoids			/ /	
Urinary:				
Urinary tract infections			/ /	
Pain/burning on urination			/ /	
Frequent urination			/ /	
Difficulty starting/stopping stream			/ /	
Kidney stones			/ /	

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REVIEW OF SYSTEMS—cont'd:

Genito-reproductive: Male	**Yes**	**No**	**Date of Onset (if unknown, leave blank)**	**Comments**
Discharge from penis			/ /	
Testicular pain			/ /	
Lumps in testicles or scrotum			/ /	
Decrease in testicular size			/ /	
Decreased sexual desire			/ /	
Decreased ability to achieve erection			/ /	
Genito-reproductive: Female				
Age of onset of periods:			/ /	
Age of menopause:			/ /	
Bleeding between periods			/ /	
Last normal period			/ /	
Do you have vaginal discharge			/ /	
Does intercourse cause pain			/ /	
Do you have decreased sexual desire			/ /	
Do you have hot flashes			/ /	
Are you taking female hormones			/ /	
Last pap smear			/ /	
Pregnancies, number:			N/A	
Number of live births:			N/A	
Musculoskeletal:				
Painful/stiff joints			/ /	
Swollen joints			/ /	
Muscle pain			/ /	
Back pain			/ /	
Endocrine:				
Heat/cold intolerance			/ /	
Tremulousness of hands			/ /	
Changes of body hair			/ /	
Increased thirst			/ /	
Increased urination			/ /	
Neurologic/Psychiatric:				
Depression			/ /	
Difficulty with sleep			/ /	
Memory changes			/ /	
Headaches			/ /	
Blackouts/Dizziness			/ /	
Weakness of limbs			/ /	
Numbness/tingling of limbs			/ /	
Loss of coordination/balance			/ /	
Skin:				
Dryness			/ /	
Rash/itching			/ /	
Changes in skin color			/ /	
Poor healing sores			/ /	
Easy bruising			/ /	
Nail changes			/ /	
Hair changes			/ /	

☐ **Yes, I confirm all information I have provided is true to the best of my knowledge.**

Patient Signature: ______________________________ **Date:** ____________

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DO NOT COMPLETE THIS SECTION
To be completed by Advanced Practice Provider / BMT Physician

*Circle **ANY** definition that applies to Recipient/Donor and document date of onset*

Co-Existing DX	Definition	Date of onset:
Arrhythmia	Atrial fibrillation or flutter, sick sinus syndrome or ventricular arrhythmias	
Cardiac	Coronary Artery Disease, congestive heart failure, myocardial infarction, or EF <50%; HTN	
CNS	Transient ischemic attack, cerebrovascular accident, paralysis, meningitis/encephalitis, seizure disorder, stroke or CVA	
Chromosome	Downs Syndrome, Fanconi anemia	
Endocrine	Diabetes, (requiring treatment with insulin or oral hypoglycemics but not diet alone) Adrenal insufficiency, osteoporosis, thyroid disease	
Heart Valve Disease	Except mitral valve prolapse	
Hematologic	DVT, PE	
Hemorrhage; Significant	GI/GU/CNS	
Hepatic, mild	Chronic hepatitis; bilirubin > ULN to 1.5 x ULN; AST/ALT > ULN to 2.5 x ULN	
Hepatic, moderate/severe	Liver cirrhosis; bilirubin >1.5 x ULN, or AST/ALT >2.5 x ULN	
Infection	Requiring continuation of antimicrobial treatment	
Gastrointestinal	Inflammatory Bowel Disease; Crohn's disease, ulcerative colitis, PUD, GERD	
Obesity	Patients with a body mass index > 35 kg/m^2	
Psychiatric disturbance	Depression or anxiety requiring psychiatric consult or treatment	
Pulmonary, moderate	DLCO and/or FEV1 66-80% or dyspnea on slight activity; asthma, restrictive lung disease	
Pulmonary, severe	DLCO and/or FEV1, < 65% or dyspnea at rest or required oxygen; COPD	
Renal, moderate/severe	Serum creatinine > 2 mg/dL or > 177 umol/L, on dialysis, or prior renal transplantation	
Auto Immune	SLE, RA, polymyositis, mixed CID, or polymyalgia/rheumatica, MS, psoriasis	
Solid Tumor, prior	Treated at any time point in the patients' past history, excluding non-melanoma skin cancer	

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BLOOD & MARROW TRANSPLANT GROUP
OF GEORGIA
5670 PEACHTREE-DUNWOODY ROAD, N.E. • SUITE 1000
ATLANTA, GEORGIA 30342

PHONE: (404) 255-1930 • FAX: (404) 459-8510

Medical Records Release Form/Request Form

As required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and Georgia law, this practice may not use or disclose your individually identifiable health information without your authorization except as provided in our Notice of Privacy Practices. Your completion of this form means that you are giving permission for the uses and disclosure described below. Please review and complete this form carefully. It may be invalid if not fully completed. You may wish to ask the person or entity you want to receive your information to complete the sections detailing the information to be released and the purpose for the disclosure.

I hereby authorize this medical Practice, **Blood and Marrow Transplant Group of Georgia** to release health information of patient named below:

Patient Name: ______________________________ **Date of Birth:** ______________

Soc. Sec. #: ______________________

(Other names, Maiden name): ____

Dates of Service to Release: ________________________ or _____ **Entire Medical Record**

Reason for Release: ____
(Reason for release must be noted on this form)

Please Print: Send medical records to:

Name: ______________________________________

____

____

Address: ______________________________________

____

____

Copyright: 1/15/2005

Restrictions: I understand that the recipient of this information may not use or disclose this information except for the expressed purposes identified above, unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

Exclusion (Please initial): Drug/Alcohol_____, Mental Health/Psychiatric_____,

Sexually Transmitted Disease_____, HIV/AIDS_____, Other_____, description of other exclusions:

I understand that I may revoke this authorization at any time by notifying this medical practice in writing as described in the Notice of Privacy Practices. My revocation will not affect actions taken by this medical practice prior to its receipt.

I understand that, if the recipient of the information is not a health care provider or health plan covered by HIPAA, the information used or disclosed as described above may be redisclosed by the recipient and no longer protected by HIPAA. However, other state or federal law may prohibit the recipient from disclosing specially protected information such as substance abuse treatment information, HIV/AIDS-related information, and psychiatric/mental health information.

I understand that, if records are requested for any other purpose other then continuation of care, claim determination or for the completion of an initial disability application that fees may apply.

Effective July 1, 2006, The Georgia Office of Planning and Budget (OPB) pursuant to O.C.G.A. § 31-33-3, calculates an annual inflation adjustment for the costs related to medical record retrieval, certification and copying. The fee scale determined by BMTGA is as follows,

Search, Retrieval, and Other Direct Administrative Costs	Up to	$24.86
Certification Fee	Up to per record	$9.32
Copying Costs for Records in Paper Form	Per page for pages 1-20	$0.93
	Per page for pages 21 - 100	$0.80
	Per page for pages over 100	$0.63

Refusal to Sign Authorization: I understand that my health care treatment or benefits will not be affected whether I sign or do not sign this form.

This authorization is effective this date: ______________________ thru ____________________
(dates must be specified)

Signature: ____________________________ **Print Name:** ______________________________

Date: __________________

I am the ____ **Patient** ____**Guardian** ____**Conservator** ____**Patient's Representative**
(If this form was completed by someone other than the patient, please print full name.)

Name: ____

I understand that I have the right to receive a copy of this authorization.

Copyright: 1/15/2005

Blood & Marrow Transplant Group of Georgia

PATIENT AUTHORIZATION
TO RELEASE PROTECTED HEALTH INFORMATION TO THIRD PARTIES
Benefit release for claims/eligibility

Patient's Name ______________________ Birth Date ____________

Patient's ID#, SSN, or Chart # (Circle One) ______________________

Street Address City State Zip ______________________

I hereby authorize BMTGA to (check all that apply):

☐ Release to: ☐ verbally only ☐ in written form only ☐ both verbally and in writing

☐ Obtain from the parties I have indicated below.

____

____

Description of individually identifiable health information (check appropriate type(s) of information) to be released/exchanged/obtained. Note: Clinical records used to make benefit determinations may include HIV/AIDS and/or Substance Abuse information.

☐ All pertinent documentation BMTGA deems appropriate for the purpose(s) checked below

☐ Treatment Plan(s)

☐ Office Notes Only

☐ Diagnostic Reports Only

☐ Claims

☐ All records relating to a Disability claim(s)

The purpose of this release is: To allow the clinically appropriate management and coordination of the Patient's health and or coverage under the Patient's health benefit plan (Care Management and Coordination).

☒ Eligibility/Benefits

☒ Benefit Management/ Claims Administration/ Payment

☒ Administration of a Worker's Compensation claim

☒ Administration of a Disability claim

☐ Subpoena or other legal process

☐ Other (describe):

____

____

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Blood & Marrow Transplant Group of Georgia

THE PATIENT OR THE PATIENT'S REPRESENTATIVE MUST READ AND SIGN OR INITIAL THE FOLLOWING STATEMENTS:

I understand that this authorization will expire:

☐ On ____/____/____ (MM/DD/YY), or upon termination of policy coverage, or 60 days after the termination of treatment, whichever is earlier.

OR

☐ Once the following event occurs:

____

____

(Form must be completed before signing)

____
Signature of Patient/Legal Guardian or Patient's Representative   Date

____
Signature of Minor Patient   Date

____ Print Name of Patient's Representative   Relationship to the Patient

The patient or the person signing this form has the right to receive a copy of this consent form. A copy of this form has been requested and received:

_____ Yes   _____ No   **Initials:** _________ (patient)

I understand that this authorization is voluntary. I understand that my health information may be protected by the Federal Rules for Privacy of Individually Identifiable Health Information (Title 45 of the Code of Federal Regulations , Parts 160 and 164), and/or state laws. I understand that my health information may be subject to re-disclosure by the recipient and that if the organization or person authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by the Federal privacy regulations. I understand that my records may contain information regarding my mental health, substance abuse, or sexuality, and also may contain confidential HIV/AIDS – related information. I further understand that by signing below, I am authorizing the release or exchange of these records to the parties named below. I also understand that my health plan may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this form, except for certain eligibility or enrollment determinations prior to my enrollment in its health plan, and for health care that is solely for the purpose of creating protected health information for disclosure to a third party.

I understand that I may revoke this authorization at any time by notifying BMTGA in writing, but if I do, it will not have any effect on any actions BMTGA took before it received the revocation.

***YOU MAY REFUSE TO SIGN THIS AUTHORIZATION*, with the understanding that this may delay patient care. Signing this form gives BMTGA staff and Northside Hospital Coordinators authorization to obtain or release medically necessary information that is pertinent to your immediate care. Refusal to sign this form may result in the delay of patient care due to insufficient documentation or vital medical information.**

(If you refuse to sign this document please initial and date) Initials:_________ Date:_________

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BMTGA Caregiver Authorization Form

Patient's Name: ______________________________

Address: ____________________________________

Social Security #: ______-______-________

Date of Birth: ___/___/___ Gender: ___ Male ___ Female

I agree to allow the caregiver named below access to my medical information currently available and that may become available as a result of future medical care. I understand I may revoke this access at any time.

☐ release to ☐ verbally only ☐ written form only ☐ both verbally and in writing

Caregiver Name (s): ______________________________
2.)______________________________
3.)______________________________
4.)______________________________

______________________________ Date ______________________________ Date
Patient Signature Witness Signature

Please enter Caregiver information below:

Primary Caregiver: ________________________

Address: ______________________________

____

Social Security #: __________ (Last 4 digits Only) Date of Birth: ___/___/___

Gender: ___ Male ___ Female

Relationship to patient: _____Son _____ Daughter _____Spouse _____Other

If other, please specify: ______________________________

Additional Caregivers:

Caregiver 2:______________________________

Caregiver 3:______________________________

Caregiver 4:______________________________

PROPER ID REQUIRED PRIOR TO RELEASE OF RECORDS

Copy write 5/8/2008

The Blood and Marrow Transplant Program at Northside Hospital
Atlanta, GA 30342

Infectious Disease Testing Consent
ACKNOWLEDGEMENT OF COUNSELING & CONSENT

Patient Name ______________________ MRN ______________________________

Patient Sex __________ Race ____________ Date of Birth ________________

County of Residence _____________________________ Zip Code ___________

I give my permission for the collection of blood specimens from me (as in other blood tests) to detect whether I have antibodies in my blood to the Human T-Cell Virus Lymphotrophic (HTLV) and/or Human Immunodeficiency Virus (HIV), which is associated with Acquired Immune Deficiency Syndrome (AIDS). A healthcare provider has counseled me regarding the HIV / HTLV antibody test and all my questions regarding the test have been answered. I understand that my blood may also be tested under an investigational research protocol. These tests are explained in attachments to this consent if indicated. I understand that I may be tested periodically under the discretion of my physician for HIV/HTLV and other infectious disease tests. I understand that I may rescind this consent at any time in writing. I understand that Blood & Marrow Transplant Group of Georgia will not release these test results or disclose the fact that I have been tested without my consent unless required or authorized by law. I understand that the results of my blood test will be reported to my doctor who will explain them to me.

I have been given an opportunity to refuse this test and I freely consent to have my blood collected and tested for the HIV / HTLV antibody, and if applicable, other infectious disease testing under an investigational protocol as described above.

If I am consenting on behalf of another, I confirm that I am the patient's parent, legal guardian, or next of kin and that the patient is unable to sign because:

____

_____________________________ _____________________________
Person Consenting to Test Relationship to Patient if not Parent

_____________________________ _____________________________
Date Witness

The Blood & Marrow
Transplant Group
OF GEORGIA

5670Peachtree Dunwoody Rd., Suite 1000, Atlanta, Georgia 30342

In an effort to continuously improve the operations of the Practice, the Clinic has implemented a system to maintain communication throughout the day between all Practice Clinicians and Caregivers. As part of this system, it is necessary to display your name and location in the Clinic during your visit. However, the Clinic wishes to meet your expectations of maintaining your privacy. Please complete the following consent form allowing the Clinic to display your name or request that your name not be displayed.

This consent will be kept on file as long as you are a patient with the Clinic. If at anytime you wish your decision to display your name or not to display your name to be changed, a new consent form can be completed.

During each of my Clinic visits, I understand that Blood & Marrow Transplant of Georgia wants to display my name ("patient") within the clinic setting, as part of an administrative communication system the Clinic utilizes.

I understand the Clinic wishes to meet my expectation of privacy. My wishes are as follows: *(initial your choice).*

______ I AGREE to allow the Clinic to display name in the Clinic setting as part of the administrative communication system the Clinic utilizes.

_____ I DO NOT want my name to be displayed in the Clinic setting as part of the administrative communication system the Clinic utilizes.

______________________ ______________________
Date Patient

______________________ ______________________
Date Staff Member - Witness

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Atlanta, GA 30342

PATIENT CONSENT FOR COMMUNICATION/NOTIFICATION DISCLOSURE OF PROTECTED HEALTH INFORMATION BY BMTGA

I [redacted] hereby give my consent for **The Blood and Marrow Transplant Group of Georgia** to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). **The Blood and Marrow Transplant Group of Georgia's** Notice of Privacy Practices provides a more complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practices prior to signing this consent. **The Blood and Marrow Transplant Group of Georgia** reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to **The Blood and Marrow Transplant Group of Georgia** Privacy Officer at 5670 Peachtree Dunwoody Road, Suite 1000, Atlanta, Georgia 30342.

With this consent, **The Blood and Marrow Transplant Group of Georgia** may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care. With this consent, **The Blood and Marrow Transplant Group of Georgia** may mail or e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

I have the right to request that **The Blood and Marrow Transplant Group of Georgia** restrict how it uses or discloses my PHI to carry out TPO.

However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

Signature ______________________ Date ______________________

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BLOOD AND MARROW TRANSPLANT GROUP OF GEORGIA

5670 Peachtree Dunwoody Road, Suite 1000
Atlanta, GA 30342

FINANCIAL POLICY GUIDELINES

The following information is provided to avoid any misunderstanding or disagreement concerning payment for professional services.

- Prompt payment allows us to control costs. Outstanding accounts cost both of us time and money; therefore, all patients are required to establish financial arrangements for payment of their account.
- As a courtesy, our practice will establish a reasonable monthly/weekly payment plan to accommodate your needs.
- It should be mentioned that your insurance coverage is an agreement between you and your insurer. Because we participate with many insurance plans, or office will continue to follow all guidelines set forth in our contract with them and provide as much assistance as possible with resolving any problems you may have. However, sometimes when it is dealing with your specific policy, we may not be able to help and it will be up to you to resolve. In that case we will provide guidance if needed.
- Each month you will receive a monthly statement for any personal balances due after insurance processes claims. This balance is due and payable within 30 days. If your payment is late, or arrangements have not already been made, we will mail you a reminder notice indicating that there is a problem with your account. If you are experiencing a set of circumstances out of your control, please contact our practice and we will be happy to make special arrangements.

I acknowledge that I understand and accept this financial policy.

______________________________ ____________________
Signature Date

____
Print Name

For your convenience, BMTGA accepts cash, personal checks, Visa, MasterCard, and Discover.

Effective Date of this Notice: April 1, 2003

BLOOD AND MARROW TRANSPLANT GROUP OF GEORGIA
ATLANTA BLOOD SERVICES
ATLANTA, GA 30342

NOTICE OF PRIVACY PRACTICES

As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (IIHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your IIHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your IIHI
- Your privacy rights in your IIHI
- Our obligations concerning the use and disclosure of your IIHI

The terms of this notice apply to all records containing your IIHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

PRIVACY OFFICER
Blood and Marrow Transplant Group of Georgia
5670 Peachtree Dunwoody Road, Suite 1000
Atlanta, Georgia 30342
(404) 255-1930

C. WE MAY USE AND DISCLOSE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI) IN THE FOLLOWING WAYS

The following categories describe the different ways in which we may use and disclose your IIHI.

1. **Treatment**- Our practice may use your IIHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your IIHI in order to write a prescription for you, or we might disclose your IIHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice – including, but not limited to, our doctors and nurses – may use or disclose your IIHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your IIHI to others who may assist in your care, such as your spouse, children or parents.

2. **Payment**- Our practice may use and disclose your IIHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your IIHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your IIHI to bill you directly for services and items.

6. **Research-** Our practice may use and disclose your IIHI for research purposes in aggregate form for certain limited circumstances. We will obtain your written authorization to use your IIHI for research purposes <u>except when:</u>

   - Our use or disclosure was approved by an Institutional Review Board or a Privacy Board
   - We obtain the oral or written agreement of a researcher that (i) the information being sought is necessary for the research study; (ii) the use or disclosure of your IIHI is being used only for the research and (iii) the researcher will not remove any of your IIHI from our practice; or
   - The IIHI sought by the researcher only relates to decedents and the researcher agrees either orally or in writing that the use of disclosure is necessary for the research and, if we request it, to provide us with proof of death prior to access to the IIHI of the decedents.

   Any published research study results will be in aggregate form. Your personal identifying information will NOT be published. Your records may be reviewed by an approved study monitor(s), clinical research employee(s) or BMT physician(s) to obtain clinical information.

7. **Serious Threats to Health or Safety-** Our practice may use and disclose your IIHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

8. **Military-** Our practice may disclose your IIHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

9. **National Security-** Our practice may disclose your IIHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your IIHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

10. **Inmates-** Our practice may disclose your IIHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

11. **Workers' Compensation-** Our practice may release your IIHI for workers' compensation and similar programs.

D. YOUR RIGHTS REGARDING YOUR IIHI

You have the following rights regarding the IIHI that we maintain about you:

1. **Confidential Communications-** You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to **Privacy Officer, The Blood and Marrow Transplant Group of Georgia, 5670 Peachtree Dunwoody Road, Suite 1000, Atlanta, Georgia 30342, (404) 255-1930** specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate **reasonable** requests. You do not need to give a reason for your request.

2. **Requesting Restrictions-** You have the right to request a restriction in our use or disclosure of your IIHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your IIHI to only certain individuals involved in your care or the payment of your care, such as family members and friends. **We are not required to agree to your request;** however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your IIHI, you must make your request in writing to **Privacy Officer, The Blood and Marrow Transplant Group of Georgia, 5670 Peachtree Dunwoody Road, Suite 1000, Atlanta, Georgia 30342 (404) 255-1930.** Your request must describe in a clear and concise fashion:

   (a) the information you wish restricted;
   (b) whether you are requesting to limit our practice's use, disclosure or both; and
   (c) to whom you want the limits to apply.

3. **Inspection and Copies-** You have the right to inspect and obtain a copy of the IIHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to **Privacy Officer, The Blood and Marrow Transplant Group of Georgia, 5670 Peachtree Dunwoody Road, Suite 1000, Atlanta, Georgia 30342 (404) 255-1930** in order to inspect and/or obtain copy of your IIHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

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ATLANTA BLOOD SERVICES
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ACKNOWLEDGEMENT OF PRIVACY PRACTICES

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THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION

I hereby acknowledge that I have received and reviewed the Notice of Privacy Practices of The Blood & Marrow Transplant Group of Georgia. I have also been notified that a revised Notice of Privacy Practices may be obtained by forwarding a written request to The Blood & Marrow Transplant Group of Georgia Privacy Officer at 5670 Peachtree Dunwoody Road, Suite 1000, Atlanta, Georgia 30342.

______________________	______________________	______________________
Patient Name (Printed)	Patient Signature	Date Acknowledged

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