HIPAA - SUMMARY OF PRIVACY NOTICE

Officer Name: Jeff Wilsman
Office Website: www.southamptonhealthcare.com
Office Phone Number: (314) 647-2200
Office Address: 2340 Hampton Ave, Saint Louis, MO, 63139

1. OUR LEGAL DUTY

Our practice is dedicated to maintaining the privacy of current and former patients' health and financial information as required by our internal policies and applicable law. We are also required by federal law to give you this notice explaining your rights, our legal duties and privacy practices. We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all PHI(Personal Health Information) that we maintain, including PHI we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request. You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information contained in this Notice.

2. USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose PHI about you for treatment, payment, and healthcare operations. For example: Treatment: We may use or disclose your PHI to a physician or other healthcare provider providing treatment to you. Payment: We may use and disclose your PHI to obtain payment for services we provide to you. Healthcare Operations: We may use and disclose your PHI in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities. Your Authorization: In addition to our use of your PHI for treatment, payment or healthcare operations, you may give us written authorization to use your PHI or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your PHI for any reason except those described in this Notice. To Your Family and Friends: We must disclose your PHI to you, as described in the Patient Rights section (Block 3) of this Notice. We may disclose your PHI to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so. Persons Involved In Care: We may use or disclose PHI to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your PHI, we will provide you with an opportunity to object to such uses or disclosures.

In the event of your incapacity or emergency circumstances, we will disclose PHI based on a determination using our professional judgment disclosing only PHI that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of PHI. Marketing Health-Related Services: We will not use your PHI for marketing communications without your written authorization. Required by Law: We may use or disclose your PHI when we are required to do so by law. Abuse or Neglect: We may disclose your PHI to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your PHI to the extent necessary to avert a serious threat to your health or safety or the health or safety of others. National Security: We may disclose to the military authorities the PHI of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials PHI required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected PHI of inmate or patient under certain circumstances. Appointment reminders: We may use or disclose your PHI to provide you with appointment reminders (such as voice-mails, e-mails, postcards, or letters).

3. PATIENT RIGHTS

Access: You have the right to inspect and obtain a copy of your protected PHI, with limited exceptions. If you request a copy of your information, we may charge you a fee for the costs of copying, mailing, or other costs incurred by us as a result of complying with your request. Requests for access to your protected PHI must be made in writing. Accounting of Disclosures: You have the right to receive a list of instances in which we or our business associates disclosed your PHI for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years. You must submit your request in writing to the contact information provided at the top of this notice. Your first request within a 12-month period is free of charge, but our practice may charge you for additional request made within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request

before you incur any costs. Requesting Restrictions: You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your PHI to only certain individuals involved in your care or the payment for 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 PHI, you must make your request in writing to the contact information provided at the top of this notice. Your request, in a clear and concise manner should describe; the information you wish restricted, whether you are requesting to limit our practice's use, disclosure or both or to whom you want the limits to apply.

Alternative Communication: You have the right to request that we communicate with you about your PHI by alternative means or to alternative locations. Your request must be in writing and specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request. Amendment: You have the right to request that we amend your PHI. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances. Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are still entitled to receive this Notice in written form.

4. QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your PHI or in response to a request you made to amend or restrict the use or disclosure of your PHI or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the top of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request. We support your right to the privacy of your PHI. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

_____ X _____ Date _____

Southampton Healthcare

Form Name: New Intake

Demographics

Please check all that Apply:

- ☐ I am a new patient (Never seen at practice)
- ☐ I am a returning patient (Have not been seen at practice in 24 months or more ☐ I am wanting to start Prep
- ☐ I am HIV+ ☐ I am Hep C+ ☐ I am seeking help for drug or alcohol addiction
- ☐ I am currently undergoing cancer treatment ☐ I am transgender (or wish to start transitioning)
- ☐ I take opioid medications daily (Hydrocodone, Oxycodone, Morphine, etc) ☐ I am on 10 or more medications

Legal First Name (What your ID and Insurance card say)

Legal Last Name (What your ID and Insurance card say)

Middle name **Preferred name**

Date of Birth **Soc. Sec #**

Street Address (inc. St, Ave, Rd, or other applicable ending)

Apartment, Suite, or Unit number **City**

State **Zip Code**

Home Phone (Enter cell if no home phone) **Cell Phone (or other secondary contact number)**

Email Address

Insurance Company Name (Put Self-pay if no ins) **Insurance Member/ID #**

Insurance Group # **Confirm Ins ID number**

Mail claims to address on back of card

Insurance Subscriber First & Last Name

Ins Subscriber Date of Birth

Relationship to Subscriber

○ Self ○ Spouse ○ Child ○ Domestic Partnership ○ Other Dependent

Secondary Insurance Company

Secondary Ins ID# **Secondary Ins Group #**

Secondary Ins Claims address

Emergency Contact Name **Emergency Contact Phone**

What is your native language?

○ English ○ Spanish ○ French ○ German ○ Korean ○ Japanese ○ Chinese ○ Arabic ○ Bosnian ○ Other

If other native language please specify here

Race

☐ African-American ☐ Asian ☐ Caucasian (White)
☐ Middle Eastern ☐ Native American ☐ Pacific Islander
☐ Other ☐ Decline to specify

Ethnicity

○ Hispanic or Latino
○ Non-Hispanic or Latino
○ Decline to Specify

What was your birth sex?

○ Female ○ Male
○ Intersex

Gender Identity

☐ Female ☐ Male ☐ Intersex ☐ Male to Female (Trans woman) ☐ Female to Male (Trans man) ☐ Non-Binary
☐ Other ☐ Decline to specify

Sexual orientation

☐ Heterosexual ☐ Homosexual ☐ Bi-sexual ☐ Pan-Sexual ☐ Asexual ☐ Other ☐ Decline to specify

Do any of the following apply to you?

☐ I am homeless (more than 30 days) ☐ I am a Migrant ☐ I do seasonal work
☐ I live on the street (Less than 30 days homeless) ☐ I am in a transitional living program ☐ None of these apply to me

Birth order (if you are 1st born, 2nd born, etc)

○ First born ○ Second born ○ Third born ○ 4th born ○ 5th born ○ 6th born ○ 7th born ○ 8th born ○ 9th born
○ 10th born

What is your employment status?

☐ Employed Full-time ☐ Employed Part-time ☐ Self-Employed ☐ Active duty military ☐ Military Reservist ☐ Retired
☐ Unemployed

Are you a college student?

○ Yes, Full-time ○ Yes, Part-time ○ No

Do you experience food insecurity? (Unable to always afford to have food to eat)

○ No, never ○ Yes, sometimes ○ Yes, having enough to eat is a constant struggle

Basic Medical Info

Please list medical issues for which you are seeking treatment.

Please list any food or drug allergies you have or put none if no known allergies

CURRENT MEDICATIONS

Please list all current medications and what condition the medications are used to treat (including suppliments and over the counter medications). Please include doseage and frequency.

Example: [Tylenol] [500mg] [every 8hrs] [as needed] for [Knee Pain]

Medication Name | **Dosage** | **Frequency** | **Medical Condition**

☐ Once Daily (every 24 hrs)
☐ Twice Daily (every 12 hrs)
☐ 3x Daily (every 8 hrs)
☐ 4x Daily (every 6 hrs)
☐ 6x Daily (every 4 hrs)
☐ Scheduled (Same time each day)
☐ PRN (as needed)

Medication Name | **Dosage** | **Frequency** | **Medical Condition**

☐ Once Daily (every 24 hrs)
☐ Twice Daily (every 12 hrs)
☐ 3x Daily (every 8 hrs)
☐ 4x Daily (every 6 hrs)
☐ 6x Daily (every 4 hrs)
☐ Scheduled (Same time each day)
☐ PRN (as needed)

Medication Name | **Dosage**

Frequency

- [ ] Once Daily (every 24 hrs)
- [ ] Twice Daily (every 12 hrs)
- [ ] 3x Daily (every 8 hrs)
- [ ] 4x Daily (every 6 hrs)
- [ ] 6x Daily (every 4 hrs)
- [ ] Scheduled (Same time each day)
- [ ] PRN (as needed)

Medical Condition

Medication Name

Dosage

Frequency

- [ ] Once Daily (every 24 hrs)
- [ ] Twice Daily (every 12 hrs)
- [ ] 3x Daily (every 8 hrs)
- [ ] 4x Daily (every 6 hrs)
- [ ] 6x Daily (every 4 hrs)
- [ ] Scheduled (Same time every day)
- [ ] PRN (as needed)

Medical Condition

Medication Name

Dosage

Frequency

- [ ] Once Daily (every 24 hrs)
- [ ] Twice Daily (every 12 hrs)
- [ ] 3x Daily (every 8 hrs)
- [ ] 4x Daily (every 6 hrs)
- [ ] 6x Daily (every 4 hrs)
- [ ] Scheduled
- [ ] PRN (as needed)

Medical Condition

Medication Name

Dosage

Frequency

- [ ] Once Daily (every 24 hrs)
- [ ] Twice Daily (every 12 hrs)
- [ ] 3x Daily (every 8 hrs)
- [ ] 4x Daily (every 6 hrs)
- [ ] 6x Daily (every 4 hrs)
- [ ] Scheduled
- [ ] PRN (as needed)

Medical Condition

Medication Name

Dosage

Frequency

- [ ] Once Daily (every 24 hrs)
- [ ] Twice Daily (every 12 hrs)
- [ ] 3x Daily (every 8 hrs)
- [ ] 4x Daily (every 6 hrs)
- [ ] 6x Daily (every 4 hrs)
- [ ] Scheduled
- [ ] PRN (as needed)

Medical Condition

Medication Name

Dosage

Frequency

- [ ] Once Daily (every 24 hrs)
- [ ] Twice Daily (every 12 hrs)
- [ ] 3x Daily (every 8 hrs)
- [ ] 4x Daily (every 6 hrs)
- [ ] 6x Daily (every 4 hrs)
- [ ] Scheduled
- [ ] PRN (as needed)

Medical Condition

Medication Name

Dosage

Frequency

- [ ] Once Daily (every 24 hrs)
- [ ] Twice Daily (every 12 hrs)
- [ ] 3x Daily (every 8 hrs)
- [ ] 4x Daily (every 6 hrs)
- [ ] 6x Daily (every 4 hrs)
- [ ] Scheduled
- [ ] PRN (as needed)

Medical Condition

Consent to Treat & Insurance Benefits Assignment

GENERAL AUTHORIZATION FOR TREATMENT/CONTACT

I authorize physicians, nurse practitioners, and/or staff of Southampton Healthcare, Inc who may attend me, their assistants, including those employed by Southampton Healthcare, Inc to provide the medical care, tests, procedures, drugs, blood and blood products, services and supplies considered advisable by my provider. These services may include pathology, radiology, emergency services and other special services ordered by my provider. In consenting to treatment, I have not relied on any statements as to results. I further authorize my provider to examine, use, store, and/or dispose of in any manner (except for organ donation and/or transplantation) any tissue, fluids or parts removed from my body. In the event that any personnel assisting in the provision of care and treatment suffer inadvertent exposure to any of my blood and/or other bodily substance that are capable of transmitting disease and I am unable to consult timely with my physician prior to testing, I consent to limited testing to determine the presence, if any, of antibodies to hepatitis A, B, and C and HIV.

I authorize Southampton Healthcare, Inc to contact me on any cell phone number provided by me for the purposes of conducting business with me or contacting me concerning my account. I consent to the use of automated dialers for that purpose.

I consent and give permission to Southampton Healthcare, Inc to photograph me for internal purposes of patient identification only. This photograph will not be used for marketing purposes without the patient's expressed consent.

Print your full name and sign:

_____ X _____ **Date** _____

RELEASE AND ASSIGNMENT OF BENEFITS

I understand that payment is due at the time service is rendered. I hereby authorize the release of any medical information to (1) an insurance company through which I claim benefits and (2) any physician involved in my medical care. I realize the authorization allows Southampton Healthcare, Inc to release any information to any of my insurers or physicians. I authorize and direct my insurers to pay directly to Southampton Healthcare, Inc and/or its physicians any and all benefits up to the amount of my bill pertaining to all charges incurred. I assign to Southampton Healthcare, Inc, including its affiliates, any and all benefits or proceeds, of any type whatsoever, to which I am entitled, with respect to the health care service(s) I receive, including but not limited to, the proceeds of any liability settlement or judgment being paid by or on behalf of a third-party and any benefits due from any third-party insurance policy. I direct that all such benefits be paid directly to Southampton Healthcare, Inc and/or its affiliates, including its physicians, and applied to my account(s) until the account(s) is paid in full. I understand that I am personally responsible for any remaining fees. If services are not covered by my insurance due to not being in network I acknowledge and understand that I will be responsible for the total cost. I hereby agree to pay all costs and reasonable attorney/collection fees in the event this account is turned over to an attorney for collection or other collections agency.

Print your full name and sign:

_____ X _____ **Date** _____

Southampton Healthcare

Form Name: Patient History

Patient History

Your Answers will remain confidential, please be honest.

Household

What is your marital status?

○ Single ○ Married ○ Widowed ○ Divorced ○ Domestic Partnership ○ Seperated ○ Other

What is your living situation?

○ Live alone ○ Live with parents ○ Live with significant other ○ Live with roommates ○ Live in nurse

Number of adults in household _____

Number of children in household (under 18) _____

Vision Screening

Do you have any problems with your vision?

○ No vision problems ○ Wear glasses/contacts ○ Legally blind ○ Assistance needed for vision problems ○ other

Hearing Screening

Do you have any problems with your hearing?

○ No hearing problems ○ Partial hearing loss ○ Deaf ○ Use assistive device ○ TTYT used
○ Assistance needed with hearing problems

Miscellaneous

Do you have a support system

○ Yes ○ No

Are there any cultural or religious concerns you may have related to our delivery of care?

○ Yes ○ No

If yes,, please explain _____

What is your highest level of education?

○ Did not finish High School ○ Finished High School ○ GED ○ Some College ○ Associates Degree
○ Bachelors Degree ○ Professional School/Masters/PHD

Do you have any community involvements?

○ Yes ○ No

Do you exercise regularly?

○ Yes ○ No

Do you have any pets?

○ Yes ○ No

Have you traveled or plan to travel outside the United States?

○ Yes ○ No

Are there any financial issues that directly impact your ability to manage your health?

○ Yes ○ No

If yes explain _____

Alcohol and Drug Use

Beacause alcohol and drug use can effect your health and can interfere with certain medications and treatments, it is important that we ask some questions about your use of them. Your answers will remain confidential, please be honest.

Alcohol Screen:

Did you have a drink containing alcohol in the last year?

○ Yes ○ No

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

○ Never (0pts) ○ Less than monthly (1pt) ○ 2-4 times a month (2pts) ○ 2-3 times a week (3pts) ○ 4 or more times a week (4pts)

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

○ Never (0pts) ○ Less than monthly (1pt) ○ Monthly (2pts) ○ Weekly (3pts) ○ Daily or almost daily (4pts)

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

○ 1-2 drinks (0pts) ○ 3-4 drinks (1pt) ○ 5-6 drinks (2pts) ○ 7-9 drinks (3pts) ○ 10 or more (4 pts) ○ N/A I do not drink Alcohol

How many caffeinated drinks (Coffee, soda, energy drinks, tea, etc) do you drink a day?

○ None ○ 1 to 2 ○ 3 to 4 ○ 5 to 6 ○ 7 to 9 ○ 10 or more

Please indicate if you have used the following drugs in the last 12 months

Heroin

○ Yes ○ No

Heroin Route

☐ Injected ☐ Intranasal ☐ Smoked

PCP

○ Yes ○ No

Ketamine

○ Yes ○ No

Cannabis (Marijuana)

○ Yes ○ No

Prescription Opiates (recreational or overuse of prescribed)

○ Yes ○ No

Ecstacy

○ Yes ○ No

LSD

○ Yes ○ No

Crack

○ Yes ○ No

Methamphetamine

○ Yes ○ No

Cocaine

○ Yes ○ No

Cocaine Route

☐ Intranasal ☐ Injected ☐ Other

Are you still using?

○ Yes ○ No

Do you need a prescription for clean needles?

○ Yes ○ No

Do you want information on treatment?

○ Yes ○ No

Are there minors (18 years or younger) at risk in the home?

○ Yes ○ No

_____

If yes how many children?

How many months ago did you last use?

○ 6-12 months ○ 12-24 months ○ more than 24 months

Are you in a treatment program?

○ Yes ○ No

Name of program

Type of program

☐ Detox ☐ Methadone ☐ Residential treatment ☐ 12 step ☐ other

Tobacco use

Smoking status?

○ Non-smoker ○ Current smoker- Very Heavy (More than 2 packs a day) ○ Current Smoker- Heavy (1-2 packs per day)
○ Current smoker- Moderately heavy (half pack to full pack) ○ Current smoker- Light (3-9 cigarettes a day)
○ Current smoker- At least 1 a day ○ Current smoker- Socially (Not everyday but when out with others)
○ Former Smoker (No longer smokes)

If former smoker, how long has it been since you last smoked?

○ Today ○ 1-3 months ○ 3-6 months ○ 6-12 months ○ 1-5 years ○ 5-10 years ○ more than 10 years

If a current smoker, are you interested in quitting?

○ Ready to quit ○ Thinking about quitting ○ Not ready to quit

How soon after you wake up do you smoke your first cigarette?

○ Within 5 minutes ○ 6 to 30 minutes ○ 31 to 60 minutes ○ after 60 minutes

Do you use any other form of tobacco

☐ Vape (Such as Juul) ☐ Chew ☐ Pouches ☐ I do not use any other form of tobacco

Sexual History

The next few topics are highly sensitive. It is important we ask some questions about your sexual history, as well as, any history of abuse. It is important to say, abuse is abuse, regardless or gender or sexual orientation. Your answers will remain confidential, please be honest.

If applicable, when was your last menstrual cycle?

Are you sexually active?

○ Yes ○ No

Please specify type(s)

☐ Vaginally ☐ Anally ☐ Orally

Have you had sex in the past 12 months?

○ Yes ○ No

How many sexual partners have you had in the last 12 months?

How many sexual partners have you had in your lifetime?

Do you use protection?

○ Yes, always ○ No ○ Sometimes

Have you ever had a sexually transmitted disease?

○ Yes ○ No

Have you had any of the following (select all that apply)

☐ Syphillis ☐ Herpes ☐ Gonorrhea- Oral ☐ Gonorrhea- Vaginally ☐ Gonorrhea- Anally ☐ Chlamydia- Vaginally
☐ Chlamydia- Anally ☐ Chlamydia- Orally ☐ HIV ☐ Other- Please specify

Other STI (STD)

History of Abuse

Do you feel safe in your home?

○ Yes ○ No

Have you ever been the victim of sexual abuse?

○ No ○ Yes, in the past ○ Yes, ongoing

Have you ever been a victim of physical abuse?

○ No ○ Yes, in the past ○ Yes, ongoing

Have you ever been a victim of verbal abuse?

○ No ○ Yes, in the past ○ Yes, ongoing

Have you ever been a victim of emotional abuse?

○ No ○ Yes, in the past ○ Yes, ongoing

Past Medical Procedures/ Surgical History

Colonoscopy

DEXA(Bone Density Scan)

Mammogram

PAP Smear

Please list past surgical procedures

Women's Health

Date of last menstrual cycle

Age of first menstruation

Age of Menopause (if applicable)

Total number of pregnancies

Number of live births

Pregnancy Complications

Delivery

Personal Medical History

Please select all that apply

☐ HIV/AIDS- List contraction date below ☐ Alcohol Abuse ☐ Acid Reflux ☐ Allergies- please specify below ☐ Anxiety
☐ Anemia ☐ Arthritis ☐ Asthma ☐ Attention-Deficit Disorder ☐ Attention Deficit/Hyperactivity Disorder
☐ Bipolar Disorder ☐ Boarderline Personality Disorder ☐ Bladder infection ☐ Cancer ☐ Chronic cough
☐ Chronic Diarrhea ☐ Dementia ☐ Depression ☐ Deep Vein Thrombosis (DVT) ☐ Diabetes Type I ☐ Diabetes Type II
☐ Drug Abuse ☐ Eating Disorder(s) ☐ Emphysema (COPD) ☐ Gout ☐ Heart Disease ☐ Insomnia
☐ Inflammatory Bowel Disease ☐ Myocardial Infarction (Heart Attack) ☐ Neuropathy ☐ Panic attacks
☐ Post-Traumatic Stress Disorder (PTSD) ☐ Osteoporosis ☐ Pulmonary Embolism ☐ Rheumatoid Arthritis ☐ Seizures
☐ Sleep Apnea ☐ Stroke ☐ Hypertension ☐ Other(s) not listed, please specify below

Please explain

Family Medical History

Are you adopted?

○ Yes ○ No

Please enter health issues, if any, for the following relatives:

Maternal Grandfather

Maternal Grandmother

Paternal Grandfather

Paternal Grandmother

Mother

Father

Spouse

Children

Southampton Healthcare

Form Name: PHQ9

Last name _____ First name _____ Date _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?

1. Little interest or pleasure in doing things

○ 0- Not at all ○ 1- Several days ○ 2- More than half the days ○ 3- Nearly every day

2. Feeling down, depressed or hopeless

○ 0- Not at all ○ 1- Several days ○ 2- More than half the days ○ 3- Nearly every day

3. Trouble falling or staying asleep, or sleeping to much

○ 0- Not at all ○ 1- Several days ○ 2- More than half the days ○ 3- Nearly every day

4 . Feeling tired or having little energy

○ 0- Not at all ○ 1- Several days ○ 2- More than half the days ○ 3- Nearly every day

5. Poor appetite or overeating

○ 0- Not at all ○ 1- Several days ○ 2- More than half the days ○ 3- Nearly every day

6. Feeling bad about yourself---or that you are a failure or have let yourself or your family down

○ 0- Not at all ○ 1- Several days ○ 2- More than half the days ○ 3- Nearly every day

7. Trouble concentrating on things, such as reading the newspaper or watching television

○ 0- Not at all ○ 1- Several days ○ 2- More than half the days ○ 3- Nearly every day

8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual

○ 0- Not at all ○ 1- Several days ○ 2- More than half the days ○ 3- Nearly every day

9. Thoughts that you would be better off dead or of hurting yourself in some way

○ 0- Not at all ○ 1- Several days ○ 2- More than half the days ○ 3- Nearly every day

_____

Total score=

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

○ Not difficult at all ○ Somewhat difficult ○ Very difficult ○ Extremely difficult

Southampton Healthcare

Form Name: Continuity of care PHI Request

Request for Protected Health Information for Continuity of Care

Previous Primary Care Provider

Previous Provider Phone Number

Previous Provider Fax Number

Previous Provider Address

Current Pharmacy

Pharmacy Name

Pharmacy Phone Number

Pharmacy Address

Please disclose the following health care information to:

Southampton Healthcare, Inc

2340 Hampton Ave

Saint Louis, MO 63139

P. (314) 647-2200 F. (314) 647-4172

Information to be disclosed

○ All my protected health information for 3 years prior to the date of this release including but not limited to: Progress Notes, Diagnostic Testing, Medication History, and evaluations; excluding Psychological, chemical dependency, and HIV records unless marked below

I specifically authorize disclosure of the following conditions (check all that apply):

☐ Drug abuse ☐ Alcohol abuse ☐ HIV/AIDS ☐ psychological or psychiatric conditions, including psychotherapy notes

This authorization is for the patient listed below

Last Name

First Name

Previous Name

Date of Birth

Please send records to:

Southampton Healthcare, Inc.

ATTN: MEDICAL RECORDS DEPT

2340 Hampton Ave.

Sant Louis, MO 63139

II. My Rights

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment, enrollment or

eligibility for benefits). However, I do have to sign an authorization form:

• To take part in a research study;

or

• To receive health care when the purpose is to create health information for a third party.

I may revoke this authorization in writing. If I revoke this authorization, it would not affect any actions already taken by the

above-named practice based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain

insurance. Two ways to revoke this authorization are:

• Fill out a revocation form. The form is available from the office; or

• Write a letter to the office.

Once the office discloses health information, the person or organization that receives it may be able to redisclose it.

Privacy laws may no longer protect it.

_____ _____ **Date** _____

Form Name: HIPPA Records Release

Southampton Healthcare, Inc

2340 Hampton Ave

Saint Louis, MO 63139

(P) 314-647-2200 (F) 314-647-4172

Web: www.southamptonhealthcare.com

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Patient's Last Name _____ Patient's First Name _____ DOB _____

I authorize Southampton Healthcare, Inc to release health information regarding the above referenced patient(s) to the following individuals:

Name of Individual _____ Relationship to Patient _____

Address _____

Phone number _____ Fax number _____

Name of Individual _____ Relationship to Patient _____

Address _____

Phone number _____ Fax number _____

Information authorized for disclosure:

☐ Complete Health Record ☐ Immunization Records ☐ Progress Reports ☐ Radiology and Diagnositc Imaging Reports
☐ Pathology Reports ☐ Laboratory Tests ☐ Behavioral Health Services/ Psychiatric Care
☐ Drug or alcohol abuse history and/or treatment ☐ Infectious or contagious disease information, including HIV/AIDS
☐ Sexually Transmitted Diseases ☐ Genetic Counseling/Testing

NOTICE

Southampton Healthcare, Inc and many other organizations and individuals such as physicians, hospitals, and health plans are required by law to keep health information confidential. If you have authorized the disclosure of your child's health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.

MY RIGHTS

1. I understand this authorization is voluntary.

2. I have a right to revoke this authorization at any time. If I decide to revoke the authorization, I must do so in writing. I can submit this to:

Southampton Healthcare, Inc
Attn: Health Information
2340 Hampton Ave
Saint Louis, MO 63139

3. I understand that revocation will not apply to information that has already been release in response to this authorization.

4. Unless otherwise revoked, this authorization expires 12 months after the date of signing this form.

I hereby release this facility, its employees, officers, and physicians from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Print your full name and sign:

_____ _____ **Date** _____

_____
Relationship to patient (if other than patient)

Southampton Healthcare

Form Name: Release of Information from Outside Sources

Release of Information from Outside Sources

Southampton Healthcare, Inc. and their doctors have the unique capabilities to access patient's medical records electronically from multiple outside sources. A few specifically are:

Any BJC Hospital [Barnes-Jewish (all), Missouri Baptist (all), Alton Memorial, Boone County, Christian, Clay County, Parkland, Progress West and Children's Hospital];

Any affiliates in the Accredited Direct Trust Bundle [www.DirectTrust.org];

Any affiliates of the Carequality Interoperability Framework [www.Carequality.org];

Any affiliates of the CommonWell Interoperability Framework [www.CommonWellAlliance.org].

and Rx External History via eclinicalworks

Exchanging health information electronically may:

Reduce the possibility of medical errors due to missing or inaccurate information

Inform a provider's treatment decisions

Improve communication, trust, and relationship between patients and providers

Reduce the burden to pick-up/deliver hard copies of medical records

Reduce the burden to remember everything about past medical history and previous visits

Reduce duplicate or unnecessary tests, immunizations, procedures and medications

This access allows the providers and staff to review past and current medical records, within these networks, to help with your medical care given at Southampton Healthcare, Inc.

We understand that privacy is a concern with patients and healthcare facilities. There are rules and configurations for sending and receiving data to and from healthcare network systems by way of electronic communication. These communication paths follow HIPAA compliant secure data exchange guidelines. These secure connections are being monitored by all affiliates as well as the Office of E-Health Standards and Services within the Centers for Medicare & Medicaid Services (CMS). These connections are only accessible by use of physician and/or employee username and password [with most instances requiring two step verification].

If you have any questions regarding this access, please speak with the receptionist and or visit the above mentioned sites.

- ○ I hearby give permission for Southampton Healthcare's physicians and employees to access my medical records the above mentioned networks.
- ○ I decline

Print your full name and sign:

_____ _____ **Date** _____

Southampton Healthcare

Form Name: Opioid Patient Prescriber Agreement

Opioid Patient Prescriber Agreement

This Opioid Patient Prescriber Agreement (PPA) is designed to: • Create an open conversation between the patient and the prescriber about the benefits, risks, and limitations of opioid medicines • Be used as a decision making tool before an opioid medicine is used for acute or persistent pain, and • Ensure the appropriate and safe use of opioid medicines Part 1: For the Patient: Deciding whether to use opioid medicines for pain

Please check each item to indicated agreement and understanding

1. Pain and pain treatment are different for each person. Opioid medicines are a type of analgesic (pain reliever) medicine used to reduce moderate to severe pain. Opioid medicines can reduce some (but not all) types of pain. It is not known how much improvement in pain, activity and quality of life I may have by using these medicines. My prescriber will routinely check how I am doing to determine whether the benefits of opioid medicines outweigh the side effects of continuing to use them.

- ○ I understand and agree

2. Pain and pain treatment are different for each person. Opioid medicines are a type of analgesic (pain reliever) medicine used to reduce moderate to severe pain. Opioid medicines can reduce some (but not all) types of pain. It is not known how much improvement in pain, activity and quality of life I may have by using these medicines. My prescriber will routinely check how I am doing to determine whether the benefits of opioid medicines outweigh the side effects of continuing to use them.

- ☐ Go back to work ☐ Climb Stairs ☐ Walk short distances ☐ Sleep through the night without pain
- ☐ Do daily household chores ☐ Start a light exercise program

3. My prescriber and I may also try alternative or additional treatment options for my condition, including:

- ☐ Non-opioid medicines (for example, over-the-counter medicines such as Tylenol®, Motrin®, Aleve® , prescription medicine such as antidepressants, or anticonvulsants, as appropriate)
- ☐ Physical therapy, appropriate exercises ☐ Acupuncture
- ☐ Self-management techniques and coping strategies such as meditation, stress reduction, counseling and coaching, massage therapy, social support group, and attention to proper sleep
- ☐ Surgical or other medical procedures

4. I need to be aware of the following side effects of using opioid medicines.

4. I need to be aware of the following side effects of using opioid medicines.

- ☐ A. Physical dependence - If I suddenly stop taking an opioid medicine, I can experience withdrawal symptoms such as a runny nose, chills, body aches, diarrhea, sweating, nervousness, nausea, vomiting and trouble sleeping. This is called physical dependence. If this happens, it can be difficult for me to stop taking an opioid medicine, even if it's not working well. So, when I stop taking an opioid medicine, I understand I will need medical supervision. My prescriber can help me gradually lower the dose and stop the opioid medicine or refer me to a specialist in a way that meets my needs.
- ☐ B. Tolerance - Over time, I might need more opioid medicine to get the same pain relief. This is called tolerance. It means that the opioid medicine may begin to feel like it's not working anymore. My prescriber can help me by making changes to the opioid medicine or refer me to a specialist in a way that meets my needs.
- ☐ C. Addiction - I may develop an intense craving for the opioid medicine, even if I take it as prescribed. When a person is not able to control their opioid medicine use and may continue using the medicine despite the side effects it causes, this is called addiction. If addiction occurs, it can be difficult to stop taking the opioid medicine, and I will need medical supervision. My prescriber can help me gradually lower the dose and stop the opioid medicine or refer me to a specialist in a way that meets my needs.

5. Table 1 - Opioid Side Effects: The table below lists common and potential opioid side effects in alphabetical order and the percentage of patients that experience them. Opioid Side Effects Percentage of Patients addiction 5 - 30% breathing problems during sleep, disruption of sleep 25% confusion * constipation 30 - 40% depression 30 - 40% drowsiness 15% dry mouth that can cause tooth decay 25% intestinal blockage <1% per year itching * lowered testosterone levels, infertility and impotence 25% - 75% nausea or vomiting * overdose – can lead to death < 1% per year physical dependence * tolerance * unexpected increased pain * *Percentage of patients experiencing side effect unknown

AnGee Baldini, Michael Von Korff, and Elizabeth H. B. Lin. A Review of Potential Adverse Effects of LongTerm Opioid Therapy: A Practitioner's Guide. Primary Care Companion CNS Disorders 2012; doi:10.4088/PCC.11m01326.

☐ I acknowledge review of Opioid Side Effects

6. Opioid medicine can impair my judgment and responses. I understand that I must be cautious if I drive or operate machinery or do any activity that requires me to be alert until I am sure I can perform such activities safely

○ I acknowledge

7. Taking even small amounts of alcohol or taking medicines such as sleeping pills, antihistamines, and anti-anxiety medicines while taking an opioid medicine will increase the chance of opioid medicine side effects. These side effects can include drowsiness, dangerously slowed breathing, and decreased alertness.

○ I acknowledge

8. It may be necessary that I routinely provide a urine, saliva, or blood sample before or while I am taking opioid medicine.

○ I acknowledge

9. I agree to discuss with my prescriber my and my family's past and present use of any habit-forming substances before we decide to try to treat my condition with an opioid medicine. These habit-forming substances can include tobacco and alcohol, as well as other opioid medicines or street drugs.

○ I acknowledge

10. My prescriber and I have discussed all the information above and have made a decision about using opioid medicines.

○ Yes, my prescriber and I have agreed to try an opioid medicine for my condition. If I check "Yes", we will continue to discuss the rest of this checklist

○ No, my prescriber and I have not agreed at this time to try an opioid medicine for my condition. If I check "No", we don't need to continue to Part 2 of this checklist.

Part 2: For the Patient: My promise to using opioid medicines safely

Now that my prescriber and I have agreed that I will try an opioid medicine, I understand that I need to take an active role in my own health care to get the most benefit and reduce the chance of side effects from using an opioid medicine. My prescriber wants me to have the following information so that I may have the best possible pain reduction while also protecting my health and reducing the chances of possible harm to myself and others while I am taking an opioid medicine.

11. I told my prescriber about all the medicines I am taking, including any prescription, over-the-counter and herbal medicines. I will also discuss with my prescriber any new medicine that I take in the future. Some medicines and other substances such as alcohol, sleeping medicines, antihistamines and anti-anxiety medicines can increase the chance of opioid medicine side effects. If I use these medicines along with an opioid medicine, they can slow my breathing. This can lead to serious problems, including an increased chance of stopping breathing and death.

○ I agree

12. If I start to have more pain or other unusual or severe side effects, I will contact my prescriber right away. We may need to change the dose or try a different opioid medicine. I will not make any changes to the opioid medicine without first talking to my prescriber.

○ I agree

13. I will tell my prescriber if I am pregnant or planning to become pregnant. Taking opioid medicine during pregnancy can harm my unborn baby.

○ I agree

14. I will not share this opioid medicine with other people. My prescriber and I have selected this opioid medicine for me, and it is only for me. It is against the law to share an opioid medicine with other people. Sharing an opioid medicine with another person can cause serious harm to them, including death.

○ I agree

15. I will keep my opioid medicine in a secure place where other people cannot reach it. If someone accidently takes some of my opioid medicine or I accidentally take too many doses, I will contact my prescriber or call the Poison Control Center at 1-800-222-1222 or 911.

○ I agree

16. I will remove expired, unwanted, or unused opioid medicine from my home to avoid accidentally harming children, other adults, or myself. • I may be able to drop off unused opioid medicine through a "medicine take-back program". A "medicine take-back program" is an official place and time for dropping off unused opioid and other medicines. • If I cannot find a "medicine take-back program" or if I want to remove the medicine from my home right away, I can flush my opioid medicine down the toilet. • My opioid medicine can also be mixed with cat litter or coffee grounds and thrown out with the household trash. • I can get more information about disposing of my opioid medicine by calling 1-888-FDA-INFO (1-888-463-6332) or at the following website http://www.fda.gov/drugs/resourcesforyou/consumers/buyingusingmedicin esafely/ensuringsafeuseofmedicine/safedisposalofmedicines/ucm186187. htm

○ I agree

Part 3: For the patient and the prescriber

My prescriber and I have discussed all the items on this checklist (or will prior to starting an opioid)

☐ Yes ☐ No

We both agree that an opioid pain medicine is the best choice for my condition at this time.

○ Yes ○ No

My prescriber and I agree that we will go over this checklist again in the future.

○ Yes ○ No

Print your full name and sign:

_____ X _____ Date _____