



### **NEW PATIENT WELCOME KIT**

Welcome to our Practice! We understand that your decision about a Family Doctor is very important, and we thank you for choosing the Family Medicine Centers of S.C. We hope you will agree that we are not just the largest, but also the best, private Family Practice in the Midlands.

In order to save you 30 to 60 minutes of extra time in our waiting room on your first visit, we have mailed you information about our Practice. There are several forms you must complete before our doctors can see you, and several things you should bring to the office so our staff can better serve you. We want to allow you enough time to carefully review these materials and fill out these forms at your convenience. Your "Welcome Kit" includes:

- (1) Patient Information Brochure: Please review the enclosed Brochure so you will know about our services and policies even before your first visit. We can then answer any questions which the Brochure didn't explain clearly.
- (2) Registration Form: Please complete this entire "Registration Form" so we will have all of your basic personal and insurance information. Our Practice must keep all of this data current so that we can file your insurance claims properly and contact you for medical matters.
- (3) Short Medical History: Please complete this entire form so we will have some basic information about your medical history, which our doctors need to evaluate and treat you properly.
- (4) Senior Survey or Annual Wellness Visit: If you are older than 50 and don't have Medicare, please complete the "Senior Survey", which will help us to better meet your health care needs. If you have Medicare (regardless of your age), please fill out the Annual Wellness Visit form instead of the Senior Survey.
- (5) Financial Policy Statement: Please review our financial policies so that you will come prepared to pay your share of the charges for each office visit. We cannot render medical care until you have signed the Payment Agreement at the bottom of this form.
- (6) Insurance Cards: Please bring your current insurance cards for every one of your medical carriers, so we can assist you in filing claims and confirm your copayments, deductibles, coinsurance and benefits.
- (7) Photo I.D.: Please bring some form of photo identification (like your Driver's License or Passport), because we are now required to confirm your identity for legal and insurance purposes.

- (8) Medication List: Please bring a complete list of all the prescription medicines and nonprescription drugs you are now taking (or are supposed to be taking), including dosage instructions. It may be easier just to bring your medicine bottles.
- (9) Previous Medical Records: We can evaluate and treat your health problems better if we have your previous medical records. Please bring these with you (or arrange to have a copy mailed to our office). You can complete and send the enclosed "Record Release Form" to your last Primary Care doctor.
- (10) Notice of Privacy Practices: Please review our "Notice of Privacy Practices", which informs you about how we can use your protected health information. Federal Law now requires that we give you the enclosed form explaining these privacy policies. Remember that we cannot discuss your medical status with (or release your medical records to) a friend or relative without your written consent.

We thank you for choosing our Practice to provide your medical care, and look forward to serving you for many years. If you have any questions about these matters, please feel free to call one of our 5 offices:

Midtown Family Medicine  
1910 Gregg Street  
Columbia, SC 29201  
Tel: (803) 931-0100  
Fax: (803) 254-2939

Springwood Lake Family Practice  
1721 Horseshoe Drive  
Columbia, SC 29223  
Tel: (803) 788-7884  
Fax: (803) 788-9489

Woodhill Family Medicine  
813 Leesburg Road  
Columbia, SC 29209  
Tel: (803) 783-4433  
Fax: (803) 695-1531

Saluda Pointe Family Medicine  
3630 Sunset Boulevard  
West Columbia, SC 29169  
Tel: (803) 239-1600  
Fax: (803) 239-1601

Lake Murray Family Medicine  
7611 St Andrews Road  
Irmo, SC 29063  
Tel: (803) 724-1100  
Fax: (803) 724-1101

**PATIENT REGISTRATION FORM**  
**Family Medicine Centers of South Carolina, LLC**

**Patient Name:** \_\_\_\_\_ **Age:** \_\_\_\_\_ **Race:** \_\_\_\_\_ **Sex:** \_\_\_\_\_  
(Last) (First) (Middle Int.)

**Address:** \_\_\_\_\_ **Apt/Box #:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_ **Marital Status:** \_\_\_\_\_

**Birth Date:** \_\_\_\_\_ **Religion:** \_\_\_\_\_ **Social Security #:** \_\_\_\_\_

**Driver's License #:** \_\_\_\_\_ **State:** \_\_\_\_\_

**Employer:** \_\_\_\_\_ **Address:** \_\_\_\_\_

**Responsible Party (if not the patient):** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Soc. Security #:** \_\_\_\_\_ **Work Phone:** \_\_\_\_\_ **Home Phone:** \_\_\_\_\_

**Employer:** \_\_\_\_\_ **Address:** \_\_\_\_\_

**Do you have Medicaid as a primary or secondary insurance plan?** \_\_\_\_\_ **Yes** \_\_\_\_\_ **No**

**Primary Insurance:** \_\_\_\_\_ **Insured Party Name:** \_\_\_\_\_

**Birth Date:** \_\_\_\_\_ **Policy #:** \_\_\_\_\_ **Group #:** \_\_\_\_\_

**Employer:** \_\_\_\_\_ **Address:** \_\_\_\_\_

**Secondary Insurance:** \_\_\_\_\_ **Insured Party Name:** \_\_\_\_\_

**Birth Date:** \_\_\_\_\_ **Policy #:** \_\_\_\_\_ **Group #:** \_\_\_\_\_

**Employer:** \_\_\_\_\_ **Address:** \_\_\_\_\_

-----  
**Local Pharmacy:** \_\_\_\_\_ **Address:** \_\_\_\_\_ **Phone #:** \_\_\_\_\_

**Mail Order Pharmacy:** \_\_\_\_\_

**AUTHORIZATION TO RELEASE INFORMATION:**

I hereby authorize Family Medicine Centers of South Carolina, LLC to release any information obtained during the course of my evaluation and treatment which is necessary for the processing of insurance claims, completion of disability statements, or documentation of services rendered.

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Signature of Patient or Guardian**

**AUTHORIZATION TO ASSIGN BENEFITS TO  
FAMILY MEDICINE CENTERS OF SOUTH CAROLINA, LLC:**

I hereby authorize payment of all applicable medical/surgical insurance benefits for the services rendered by Family Medicine Centers of South Carolina, LLC directly to Family Medicine Centers of South Carolina, LLC. I understand that I am responsible for all charges not paid in full by my health insurance carriers, including all applicable co-payments, deductibles and co-insurance amounts.

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Signature of Patient or Guardian**

**HOW CAN WE REACH YOU?**

As your primary care provider, Family Medicine Centers will need to contact you. Please fill out the information below so we may better serve you.

Name (please PRINT) \_\_\_\_\_

Home #: \_\_\_\_\_ Cell #: \_\_\_\_\_ Work #: \_\_\_\_\_

Email Address: \_\_\_\_\_ Best way to contact you: \_\_\_\_\_

Emergency contact: \_\_\_\_\_ Phone #: \_\_\_\_\_ Relationship: \_\_\_\_\_

Using the following: cell number, email address, home number, text message, work number; indicate your contact preferences: 1<sup>st</sup> \_\_\_\_\_ 2<sup>nd</sup> \_\_\_\_\_ 3<sup>rd</sup> \_\_\_\_\_

In effort to protect your privacy, we have developed a policy on leaving medical care messages:

- We will **NOT** leave messages with anyone except the patient or legal guardian.
- We will **NOT** leave any confidential information on an answering machine.
- We will **NOT** leave any message on a voicemail.
- We will **NOT** send emails.

**UNLESS**  
**WE HAVE YOUR WRITTEN PERMISSION TO DO SO.**

**Please read below and consider carefully whom you authorize to have access to protected information regarding your medical care.**

I, \_\_\_\_\_, give Family Medicine Centers of SC my permission to speak with and/or leave phone messages regarding my medical care and/or billing concerns/questions with the following. I fully understand that this consent will remain valid until revoked in writing.

My Home voicemail: \_\_\_\_\_ Initials \_\_\_\_\_      My Work voicemail: \_\_\_\_\_ Initials \_\_\_\_\_

My Cell voicemail: \_\_\_\_\_ Initials \_\_\_\_\_      My Spouse/Guardian: \_\_\_\_\_ Initials \_\_\_\_\_

Email: \_\_\_\_\_ Initials \_\_\_\_\_      Other: \_\_\_\_\_ Phone #: \_\_\_\_\_ Initials \_\_\_\_\_

**AUTHORIZATION TO COMMUNICATE ACCORDING TO PREFERENCE:**

I authorize Family Medicine Centers of South Carolina, LLC to send me communications in accordance with the above listed preferences. I understand that I can change my preferences at any time by contacting Family Medicine Centers of South Carolina, LLC directly. I understand that my medical information will never be delivered by Text Message or email without my express consent.

Standard message and data rates may apply. I understand that I may be billed by my mobile carrier for receiving text messages in accordance with my mobile agreement. Text messages may not be delivered to me if my phone is not in range of a transmission site, or if sufficient network capacity is not available at a particular time.

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Signature of Patient or Guardian**

# MEDICAL HISTORY

FAMILY MEDICINE CENTERS OF SOUTH CAROLINA, LLC

PLEASE PRINT

PATIENT'S NAME: \_\_\_\_\_ SOCIAL SECURITY #: \_\_\_\_\_

LIST ANY SERIOUS OR LONG-TERM MEDICAL PROBLEMS YOU HAVE:

_____	_____
_____	_____
_____	_____

LIST ANY MEDICINES YOU ARE NOW TAKING ON A REGULAR BASIS:

_____	_____
_____	_____
_____	_____

LIST ANY MEDICINES YOU CANNOT TAKE BECAUSE OF SIDE-EFFECTS/ALLERGIES:

_____	_____
_____	_____
_____	_____

LIST ANY SURGERY, SERIOUS ILLNESS / INJURY, OR HOSPITAL ADMISSIONS YOU HAVE HAD:

_____	_____
_____	_____
_____	_____

LIST YOUR DAILY USE OF THE FOLLOWING SUBSTANCES:

Tobacco: \_\_\_\_\_ Alcohol: \_\_\_\_\_ Caffeine: \_\_\_\_\_

Recreational or Illegal Drugs: \_\_\_\_\_

LIST ANY MEDICAL PROBLEMS WHICH HAVE OCCURED IN CLOSE RELATIVES:

Diabetes: \_\_\_\_\_ Heart Disease: \_\_\_\_\_ Allergies/Asthma: \_\_\_\_\_

Cholesterol: \_\_\_\_\_ Stroke: \_\_\_\_\_ Cancer: \_\_\_\_\_

High Blood Pressure: \_\_\_\_\_ Thyroid: \_\_\_\_\_ Other: \_\_\_\_\_

WHO REFERRED YOU TO OUR OFFICE? \_\_\_\_\_

## 2016 SENIOR WELLNESS SURVEY

Please answer these questions while you're waiting to see the doctor today, and give this survey to the nurse when you enter the exam room. This will save you, the nurse and the doctor time, and make sure you receive appropriate wellness care.

- ❖ For WOMEN – When and where was your last DEXA Bone Density Scan for Osteoporosis?

---

- ❖ For WOMEN – Do you have a problem with bladder control or urine leakage?

\_\_\_\_\_ Yes                      \_\_\_\_\_ No

- ❖ For WOMEN – When and where did you get your last breast Mammograms?

---

- ❖ How many times in the last year have you had 4 or more alcohol drinks in a single day?

---

- ❖ Do you smoke or use tobacco products?

\_\_\_\_\_ Yes                      \_\_\_\_\_ No

- ❖ Have you had Influenza (Flu) vaccine within the past 15 months?

\_\_\_\_\_ Yes                      \_\_\_\_\_ No                      \_\_\_\_\_ Not Sure

- ❖ Have you ever had Pneumococcal (Pneumonia) vaccine?

\_\_\_\_\_ Date                      \_\_\_\_\_ Never                      \_\_\_\_\_ Not Sure

- ❖ Have you had a stool test to check for blood in your bowel movements within the past year?

\_\_\_\_\_ Yes                      \_\_\_\_\_ No

- ❖ Have you gained or lost more than 10 pounds in the past year?

\_\_\_\_\_ Yes                      \_\_\_\_\_ No                      \_\_\_\_\_ Not Sure

- ❖ Have you been feeling sad, depressed or hopeless lately?

\_\_\_\_\_ Never                      \_\_\_\_\_ Sometimes                      \_\_\_\_\_ Often                      \_\_\_\_\_ Daily

- ❖ Have you felt little interest or pleasure in doing things lately?

\_\_\_\_\_ Never                      \_\_\_\_\_ Sometimes                      \_\_\_\_\_ Often                      \_\_\_\_\_ Daily

**MEDICARE ANNUAL WELLNESS VISIT**

**FAMILY MEDICINE CENTERS OF SOUTH CAROLINA, LLC**

\_\_\_\_Springwood Lake    \_\_\_\_Midtown    \_\_\_\_Woodhill    \_\_\_\_Saluda Pointe    \_\_\_\_Lake Murray

Name: \_\_\_\_\_ Ethnic Background: \_\_\_\_\_

Race: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Marital Status: \_\_\_\_\_

**PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT YOUR OWN MEDICAL HISTORY:**

(1) Chronic Medical Problems (i.e.: Diabetes, Hypertension, Arthritis, Heart Disease, Thyroid, Asthma, Depression, etc.):

\_\_\_\_\_  
\_\_\_\_\_

(2) Current Medicines & Supplements (i.e.: Heart drugs, Inhaler, Insulin, Antacid, Hormone, Blood Thinner, Vitamins):

\_\_\_\_\_  
\_\_\_\_\_

(3) Serious Illnesses (i.e.: Hepatitis, HIV, Ulcer, TB, Kidney Stones, Meningitis, Pneumonia, Heart Attack, Stroke, etc.):

\_\_\_\_\_  
\_\_\_\_\_

(4) Major Injuries (i.e.: Fracture, Burn, Concussion, Gunshot, Torn Cartilage, Ruptured Spleen, Ruptured Disc, etc.):

\_\_\_\_\_  
\_\_\_\_\_

(5) Surgery (i.e.: Biopsy, Tonsils, Appendix, Gall Bladder, Hernia, Coronary Bypass, Hip, Knee, Colonoscopy, etc.):

\_\_\_\_\_  
\_\_\_\_\_

(6) Hospital Admissions (i.e.: Serious Illness, Bad Injury, Surgery, Pregnancy, Nervous Breakdown, Diagnostic Work, etc.):

\_\_\_\_\_  
\_\_\_\_\_

(7) Physical Impairments (i.e.: Deafness, Eye Glasses, Dentures, Cane, Colostomy, Birth Defect, Amputation, etc.):

\_\_\_\_\_  
\_\_\_\_\_

(8) Allergies/Drug Reactions (i.e.: Insect Bites, Hives, Asthma, Hay Fever, Sinus, Eczema, Drug Reaction, etc.):

\_\_\_\_\_  
\_\_\_\_\_

(9) Habits (i.e.: Smoking, Alcohol, Caffeine, Laxatives, Nasal spray, Pain Medicine, Illegal Drugs, etc.):

\_\_\_\_\_  
\_\_\_\_\_

(10) Social Background (i.e.: Education, Employment, Marital Status, Children, Military, Hobbies, etc.):

\_\_\_\_\_  
\_\_\_\_\_

(11) Do you have any medical problems now that require prompt medical attention?

\_\_\_\_\_  
\_\_\_\_\_

(12) Please list the doctors, other medical providers and suppliers you have used within the past 3 years (i.e.: Podiatrist, Specialists, Gynecologist, Psychiatrist, Optometrist, Chiropractor, Physical Therapist, equipment supplier, etc.):

\_\_\_\_\_  
\_\_\_\_\_

**FAMILY MEDICAL HISTORY**

LIST ANY DISEASES THAT OCCUR IN MULTIPLE BLOOD RELATIVES:

_____	_____	_____
_____	_____	_____
_____	_____	_____

	END-OF-LIFE PLANNING	YES	NO
(1)	Do you have a written <u>Will</u> which conveys ownership of your property after your death?		
(2)	Have you appointed an <u>Executor</u> to manage your estate after your death?		
(3)	Do you have a <u>Living Will</u> or some other written end-of-life medical directives?		
(4)	Have you appointed a <u>Health Care Agent</u> who can make medical decisions for you just in case you're not able to do so in the future?		
(5)	Have you read the " <u>5 Wishes for End-of-Life Planning</u> "?		

	HEALTH & SAFETY RISKS	YES	NO
(1)	Do you have any safety concerns in your home, workplace, or community?		
(2)	Do you engage in exotic travel or risky activities (i.e.: motorcycle, surfing, skiing, etc.)?		
(3)	Do you <u>fail</u> to wear your seat belt regularly while in a vehicle?		
(4)	Do you have a problem with poor balance/coordination or frequent falls?		
(5)	Has your vision gotten worse lately?		
(6)	Has your hearing gotten worse lately?		
(7)	Do you have chronic or severe pain not well-controlled by your current treatment?		
(8)	Do you have any foot, neck, back or joint problems that impair your function?		
(9)	Do you have sleep problems, bad snoring, or bothersome daytime drowsiness?		
(10)	Have you had problems with bowel or bladder control?		
(11)	Do you have a problem with your sexual function which is bothersome to you?		
(12)	Do you currently smoke or use tobacco?		
(13)	Do you consume more than 2 drinks of liquor, wine or beer per day on the average?		
(14)	Has your weight increased or decreased more than 20 pounds over the past 2 years?		
(15)	Do you get <u>less</u> than 2 hours of exercise per week?		

	MENTAL HEALTH STATUS	YES	NO
(1)	Have you or others noticed that your memory or thinking ability are worse lately?		
(2)	Have you or others noticed that you seem to be tense, nervous or anxious lately?		
(3)	Do you tend to worry a lot lately?		



**PATIENT HEALTH QUESTIONNAIRE – 9**

	<b>Over the <u>last 2 weeks</u>, how often have you been bothered by any of the following problems? (Circle your answers)</b>	<b>NOT AT ALL</b>	<b>SEVERAL DAYS</b>	<b>MANY DAYS</b>	<b>EVERY DAY</b>
(1)	Little interest or pleasure in doing things	0	1	2	3
(2)	Feeling down, depressed or hopeless	0	1	2	3
(3)	Trouble falling or staying asleep, or sleeping too much	0	1	2	3
(4)	Feeling tired or having very little energy	0	1	2	3
(5)	Poor appetite, or overeating	0	1	2	3
(6)	Feeling bad about yourself, or feeling that you are a failure	0	1	2	3
(7)	Trouble concentrating on things (such as the newspaper or TV)	0	1	2	3
(8)	Moving or speaking so slowly that other people might have noticed, or being very fidgety and restless	0	1	2	3
(9)	Thought that you would be better off dead or might hurt yourself	0	2	4	6

\_\_\_\_\_ + \_\_\_\_\_ + \_\_\_\_\_

Total Score: \_\_\_\_\_

---

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

Not difficult  
at all

Somewhat  
difficult

Very  
difficult

Extremely  
difficult

---

ACTIVITIES OF DAILY LIVING

CHECK YOUR CURRENT LEVEL OF FUNCTION FOR EACH OF THE DAILY LIVING ACTIVITIES LISTED BELOW:

<b>Activities</b>	<b>Don't Need Help</b>	<b>Sometimes Need Help</b>	<b>Must Have Help</b>
Bathing			
Dressing			
Grooming			
Dental Care			
Using the Toilet			
Transferring			
Walking			
Climbing Stairs			
Eating			
Cooking			
Shopping			
Reading			
Managing your Medicines			
Using the Phone			
House Work			
Doing Laundry			
Driving			
Managing your Finances			

	<b>PREVENTIVE MEDICINE MEASURES</b>	<b>YES</b>	<b>NO</b>
(1)	Have your Blood Sugar and Cholesterol been checked within the past 2 years?		
(2)	Has your stool been checked for blood within the past year?		
(3)	Have you had a screening Colonoscopy for Colon Cancer within the past 5 years? Where _____		
(4)	Have you had a Complete Physical Examination within the past 2 years?		
(5)	Have you had an eye exam within the past 2 years? Where _____		
(6)	Have you seen a dentist within the past 2 years?		
(7)	Have you had Pneumococcal (Pneumonia) Vaccine within the past 10 years?		
(8)	Have you had Influenza (Flu) Vaccine within the past year?		
(9)	Have you had a Tetanus booster within the past 10 years?		
(10)	Have you ever had Shingles Vaccine?		
(11)	If male, have you had a PSA test for Prostate Cancer within the past 2 years?		
(12)	If female, have you taken Osteoporosis medicine with the past year?		
(13)	If female, have you had a DEXA Bone Density Scan within the past 2 years? Where _____		
(14)	If female, have you had Mammograms within the past 2 years? Where _____		
(15)	If female, have you had a Pap Smear within the past 2 years? Where _____		

VITAL SIGNS & VISUAL ACUITY

Weight \_\_\_\_\_  
Height \_\_\_\_\_  
BMI \_\_\_\_\_  
Pulse \_\_\_\_\_  
BP \_\_\_\_\_  
Resp \_\_\_\_\_  
Temp \_\_\_\_\_

FAR VISION

Corrected \_\_\_\_\_  
Uncorrected \_\_\_\_\_  
Right Eye \_\_\_\_/\_\_\_\_  
Left Eye \_\_\_\_/\_\_\_\_  
Both Eyes \_\_\_\_/\_\_\_\_  
iFOB \_\_\_\_\_

PROVIDER CHECK-LIST

- (1) Review Personal Medical & Social History \_\_\_\_\_
- (2) Review Family Medical History \_\_\_\_\_
- (3) Review End-Of-Life Planning \_\_\_\_\_
- (4) Review Health & Safety Risks \_\_\_\_\_
- (5) Review Mental Health Status \_\_\_\_\_
- (6) Review Activities of Daily Living \_\_\_\_\_
- (7) Review Preventive Medicine Measures \_\_\_\_\_
- (8) Provide Patient Education and Counseling (if appropriate). \_\_\_\_\_
- (9) Schedule a complete Physical Exam or regular office visit (if appropriate). \_\_\_\_\_
- (10) Schedule Preventive Medicine services such as DEXA, Mammograms, Pap Smear, Colonoscopy, etc. (if appropriate). \_\_\_\_\_
- (11) Refer to other medical providers within or outside of the Practice (if appropriate). \_\_\_\_\_
- (12) Provide Nutrition Guidelines. \_\_\_\_\_
- (13) Personal Health Care Plan for the next 3 years. \_\_\_\_\_
- (14) Provide Preventive Medicine Check List. \_\_\_\_\_

\_\_\_\_\_ IPPE

\_\_\_\_\_ IAWV

\_\_\_\_\_ SAWV

Physician Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## FINANCIAL POLICY STATEMENT

### FAMILY MEDICINE CENTERS OF SOUTH CAROLINA, LLC

You or your employer have chosen a specific insurance policy and we must follow its guidelines. Our Practice is not responsible for setting your benefit limits, co-payments, deductible amounts or co-insurance fees. We must deal with nearly 200 different insurance plans, and these are constantly changing from year to year, so our staff may not know all the details of your current plan. You should notify us about any change in your insurance coverage, employer, home address, or telephone numbers. We must have your current information to help you and our Practice get prompt reimbursement from the insurance carrier. Please bring your insurance card and effective date of coverage with you on each office visit so we can keep a copy in your chart. If you have already met your deductible limit for the year, kindly bring the confirmation statement from your insurance company so we know what portion of your charges for a given visit will be covered by your insurer. Your quoted charges at the time of service are an estimate. The actual amount due from you may vary depending on your insurance policy, yearly deductible amount to date, and any additional services ordered by your physician later.

Our Practice is a participating provider with most (but not all) health insurance companies in this area. These carriers require the Practice to follow certain rules and fee schedules. We must therefore collect all applicable co-payments, deductible amounts, co-insurance fees, and non-covered charges at the time of service. If our staff fails to do so, then most insurers will reduce our reimbursement. For this reason, we expect you to pay all charges not covered by your carrier on the day of your office visit (not after the insurance company processes your claim). It costs our Practice every time we send a bill, so we charge a \$15 Processing Fee if you don't pay your share of the charges on a given date of service.

We reserve a specific time slot for you when scheduling an office visit, so a \$25 charge will be billed to your account if you miss a routine appointment and \$50 will be billed to your account if you miss a scheduled procedure, consultation or physical exam (24 hours advance notice is required to cancel or re-schedule appointments). Please note that we charge a \$30 processing fee for "bad checks" returned by the bank if your check doesn't clear. Should it become necessary to contact you regarding a past due amount, your signature below grants Family Medicine Centers of South Carolina, LLC or it's agent the authority to use the contact information provided to the Practice for collection efforts.

As a courtesy to our patients, we will send a claim to your insurance carriers on your behalf. We will assist you in trying to collect from your insurer any reimbursement that is truly covered by your policy, but we expect you to pay for any charges that are your responsibility. The Practice won't bill you for charges that we expect to collect from your insurance company, but we will bill you on a monthly basis for any outstanding co-payments, deductible amounts, co-insurance fees, non-covered services, or other charges that are not paid by your health plan. A service charge of 1% per month will be applied to all unpaid balances more than 90 days past due. If you have any questions about your charges, please call our Billing Office at (803) 779-1420 (Extension #1618).

---

Date

---

Signature of Patient or Guardian



## MEDICAL RECORDS RELEASE FORM

### **OBTAIN RECORDS FROM:**

\_\_\_\_\_  
(Physician /Provider)

\_\_\_\_\_  
(Address)

\_\_\_\_\_  
(Telephone Number)

\_\_\_\_\_  
(Fax Number)

### **REGARDING:**

\_\_\_\_\_  
(Patient's Name)

\_\_\_\_\_  
(Social Security Number)

\_\_\_\_\_  
(Date of Birth)

I authorize you to forward a copy of my medical records as indicated below:

(1) Send my records for a specific problem or date of service: \_\_\_\_\_

(2) Send all of my medical records in your possession.

Please forward my records to the following Provider:

\_\_\_ Midtown Family Medicine  
1910 Gregg Street  
Columbia, SC 29201  
(803) 931-0100-tel  
(803) 254-2939-fax

\_\_\_ Springwood Lake Family Practice  
1721 Horseshoe Drive  
Columbia, SC 29223  
(803) 788-7884-tel  
(803) 788-9489-fax

\_\_\_ Woodhill Family Medicine  
813 Leesburg Road  
Columbia, SC 29209  
(803) 783-4433-tel  
(803) 695-1531-fax

\_\_\_ Saluda Pointe Family Medicine  
3630 Sunset Boulevard  
West Columbia, SC 29169  
(803) 239-1600-tel  
(803) 239-1601-fax

\_\_\_ Lake Murray Family Medicine  
7611 St Andrews Road  
Irmo, SC 29063  
(803) 724-1100-tel  
(803) 724-1101-fax

\_\_\_\_\_  
This authorization shall expire in 60 days unless otherwise indicated here \_\_\_\_\_

\_\_\_\_\_  
(Patient Signature/if Representative, give relationship)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Witness Signature)

\_\_\_\_\_  
(Date)

### **REVOCAATION STATEMENT**

I understand that I may revoke or rescind this record release authorization at any time by signing the Revocation Statement on this form. I further understand that any action taken on this record release authorization prior to the revocation date is legal and binding.

I hereby request that this authorization to disclose my health information be rescinded,

\_\_\_\_\_  
(Signature of Patient or Guardian)

\_\_\_\_\_  
(Date)

FAMILY MEDICINE CENTERS OF SOUTH CAROLINA, LLC  
“NOTICE OF PRIVACY PRACTICES” FOR PERSONALLY IDENTIFIABLE  
AND PROTECTED HEALTH INFORMATION

This notice describes how personal and medical information about you may be used or disclosed by our Practice and how you can get access to this information according to the provisions of HIPAA.

**I. Definitions:**

- (A) “HIPAA” means the Health Insurance Portability and Accountability Act of 1996 (and its subsequent amendments).
- (B) “Personal Information” means all personally identifiable information that refers or relates to a specific Patient, including (but not limited to) an individual’s name, address, telephone number, fax number, e-mail address, social security number, and Protected Health Information.
- (C) “Protected Health Information” means personally identifiable information about the physical condition or mental health of a specific Patient, provision of health care to a specific Patient, or payment for provision of health care to a specific Patient that is created, stored, received or transmitted by a Provider, health plan, employer or health care clearing house.
- (D) “Patient” means a specific individual who receives health care services from a Provider or is billed for such services.
- (E) “Provider” means a supplier of medical services and any other entity that furnishes, bills or is paid for health care services.
- (F) “Practice” means the Family Medicine Centers of South Carolina, LLC

**II. Privacy and Confidentiality of Personal Information:** We acknowledge that Patients have a right to strict privacy regarding all Personal Information that refers or relates to them. This Privacy Policy sets forth the commitment of our Practice to protect the confidentiality and security of your Personal Information with a reasonable degree of care. We will hold all Personal Information in confidence for as long as we create, process, store or transmit that information.

**III. Uses and Disclosures of Personal Information.** We will not use or disclose Personal Information except:

- (A) As specifically required or permitted by all applicable laws and regulations.
- (B) To the extent required or permitted by subpoena, court order, and other judicial or administrative proceedings, including Workers’ Compensation proceedings.
- (C) As expressly permitted in writing by you, the Patient.
- (D) As necessary to administer, provide or process a transaction, product or service that you, the Patient, have requested, authorized or received.

**(1) Treatment:**

Our Practice may use or disclose your Personal Information as needed in order to provide, coordinate or manage your health care and related services. This includes communicating with other medical providers to assist in coordinating and managing your health care. We will share your Personal Information with doctors, nurses, technicians and other personnel involved in providing services to you. For example, must give our x-ray technicians enough information about your health status so they will know which body part to x-ray and the radiologist who reviews your films will know what problem prompted the study. If your x-ray reveals a significant problem requiring referral to a specialist, your doctor will disclose information about you to the specialist so that appropriate medical care can be provided. Disclosing your Personal Information to another provider would be especially important if you have medication allergies, chronic medical conditions, regular medication use, or a complicated problem.

**(2) Payment for Services:**

Family Medicine Centers of South Carolina may use and disclose your Personal Information to our staff, billing agencies and designated health insurance carriers to bill and collect payment for medical services you have received. We may share Personal Information with your health insurance carrier to determine coverage status prior to providing services. We may share Personal Information with employees who prepare bills and manage client accounts in order to ensure payment for services rendered. We

may share your Personal Information with your insurance company or health plan administrator to authorize and document your medical care. We may also share your Personal Information with staff who review client services to make certain that you have received quality health care. Portions of your Personal Information could be shared with public health and consumer reporting agencies that study medical trends. For example, the services provided to you must be transmitted to our Billing Department and your health insurance carrier so that the bill can be paid or you can be reimbursed appropriately. We may also send your Personal Information to some other agency, carrier or Provider to ensure that your referral to that provider is processed properly and your insurance carrier has authorized all appropriate services.

**(3) Quality Assurance Measures:**

Our Practice must cooperate with outside organizations and agencies that review the quality of care we provide. For example, we may use your Personal Information for government agencies, professional accrediting bodies or other licensing bureaus to document that you received quality medical care. Our Practice may use or disclose your Personal Information to review and evaluate the performance of our staff and providers. For example, we may use your Personal Information in reviewing your case to determine if you have received appropriate treatment.

**(4) Continuing Professional Education and Certification:**

Our Practice must cooperate with outside organizations that evaluate, certify or license health care providers. We may also use your Personal Information for educational purposes within the Practice so that our staff and providers can fulfill professional certification requirements. For example, your doctor may review your laboratory and x-ray studies with our technologists to ensure that these tests have been performed properly.

**(5) Compliance With Laws and Regulations:**

Our Practice may use your Personal Information when other providers, consultants or agencies assist us or monitor our compliance with specific laws and regulations governing the practice of medicine or the provision of health care services. For example, we may use your Personal Information to demonstrate to some government agency that we have protected the privacy and security of your Personal Information in accordance with HIPAA regulations.

**IV. Other Use or Disclosure of Personal Information**

**(A) Mandatory Disclosure of Personal Information.**

Family Medicine Centers of South Carolina may use or disclose your Personal Information under various circumstances where you aren't required to give authorization or don't have an opportunity to object. These are circumstances which government agencies and regulations consider so important that Personal Information may be disclosed without the Patient's permission, including use or disclosure:

- (1) Required by law
- (2) Necessary for public health activities
- (3) Regarding abuse, neglect or domestic violence
- (4) For health oversight activities
- (5) For law enforcement purposes
- (6) For court proceedings
- (7) Relating to death
- (8) Relating to cadaver organs, eye or tissue donations
- (9) Relating to medical research
- (10) Relating to health or safety threats
- (11) Relating to special government functions
- (12) For correctional/custodial situations
- (13) For Workers' Compensation cases

**(B) Use or Disclosure of Personal Information with Advance Notice.**

The Practice generally will not use or disclose your Personal Information without your authorization except as stated above. However, there are other situations where we may use or disclose such information if we notify you in advance of our intention to do so and you don't object. For example, we may share your Personal Information with a family member, friend or

other person directly related to your medical care (or payment for your medical care) if you don't object when it's necessary to notify such individuals of your location, treatment and general condition and you are unable to do so.

**(C) Use or Disclosure of Personal Information in Contacting You.**

The Practice may use your Personal Information to contact you, the Patient, for various reasons. For example, our Practice may send an appointment reminder to your home or call to remind you of a scheduled appointment.

**V. Representations and Warranties.**

You represent and warrant that all Personal Information you have provided to our Practice is true, accurate, complete and current on the date that you provided such Personal Information. You promise to promptly correct or amend all false, inaccurate, incomplete or outdated Personal Information.

**VI. Patient Rights.**

Patients have certain rights under HIPAA regulations to request a modification of, gain access to, receive copies of, or receive an accounting of the use and disclosure of their Personal Information.

**(A) Right to Communicate by Other Means.**

We will accommodate any reasonable patient request to receive and send Personal Information by alternative means or to alternative locations. However, the Practice reserves the right to receive payment for reasonable costs (such as copying and mailing charges) before complying with such requests.

**(B) Right to Inspect and Copy Personal Information.**

For so long as our Practice maintains your Personal Information, you may inspect and obtain a copy of all such Personal Information. If you wish to obtain copies by mail, our Practice may take up to Thirty (30) days to provide the requested copies. Your written request must clearly identify all records that you wish to obtain and provide your current mailing address. You will be billed for all reasonable costs (such as copying and mailing charges). Upon receipt of your payment, the Practice will mail the requested documents to your current address.

**(C) Right to Request Amendment of Personal Information.**

You may request that our Practice amend or modify Personal Information if you discover any inaccurate or incomplete information. The Practice has up to Ninety (90) days to act on your request. If your request is denied in whole or in part, our Practice will provide you with a written explanation for such denial. Needless to say, our Practice cannot falsify or otherwise amend your Personal Information or medical records in any manner that would alter, distort or delete genuine medical data or necessary health care documentation.

**(D) Right to File a Complaint.**

If you believe that your privacy rights or the privacy rights of any Patient treated by our Practice have been violated, you may file a complaint to our Practice at the address set forth below. In addition, you may file a complaint with the Secretary of the U.S. Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue S.W., Washington, D.C., 20201. We will take no action against you for filing a complaint with our Practice or the Department of Health and Human Services regarding such Personal Information matters.

**(E) Right to Receive an Accounting.**

Our Practice will promptly respond to your written request for an accounting of any disclosure of your Personal Information during the Six (6) years prior to the date of your request. You will be billed for all reasonable costs (such as copying and mailing charges) incurred by our Practice to produce such an accounting. Upon receipt of your payment, our Practice will mail the accounting of Personal Information disclosures to the address listed in your request. However, such accounting need not include disclosures of your Personal Information under the following circumstances:

- (1) To provide medical treatment or collect payment for medical services rendered.
- (2) To you, the Patient.
- (3) To the Patient about whom such Personal Information refers.
- (4) Regarding any disclosures of Personal Information prior to the HIPAA compliance date.



**(F) Right to Request Restrictions on Use and Disclosure.**

You may request that our Practice restrict the use or disclosure of your Protected Health Information. Such requests may include limiting the use or disclosure of Personal Information regarding medical treatment, health status, and reimbursement for medical services. However, our Practice cannot falsify or otherwise amend your Personal Information or medical records in any manner that would alter, distort or delete genuine medical data or necessary health care documentation.

**VII. Personal Information After Termination.** During the entire time that our Practice retains your Personal Information, our Practice shall comply with all provisions set forth in this Privacy Policy, including but not limited to the privacy, confidentiality and security obligations stated herein.

**VIII. Extent of Obligation.** The use and disclosure of certain Personal Information is regulated by the HIPAA Privacy Regulations, which will supersede any discrepancy between this Notice of Privacy Policy and all applicable HIPAA provisions. This Privacy Policy is intended to obligate our Practice to protect Personal Information to the extent required by all applicable laws, including but not limited to HIPAA. Therefore, our Practice shall endeavor to obtain written agreement from other Business Associates and entities who may acquire your Personal Information from or on behalf of our Practice. You understand and agree that our Practice shall not be held liable for any improper use or disclosure of Personal Information by any other person or entity which is not under the direction or control of our Practice or for breach of any privacy concerns which are not required by applicable law.

**IX. Applicability of Policy.** This policy does not apply to information that is “De-identified.” “De-identified” information is not considered to be Personal Information because it does not identify or relate to any individual Patient and cannot be used to identify or specify any individual Patient.

**X. Questions and More Information.** If you have any questions regarding the Privacy Policy of our Practice or the matters addressed in this Notice, you may contact our Practice as follows: Family Medicine Centers of South Carolina, LLC, 1910 Gregg Street, Columbia, S.C., 29201. Our Business Office phone number is (803) 779-1420, and our fax number is (803) 931-0676.

All forms mentioned in this document may be obtained at any of our business locations. We reserve the right to modify this Notice at any time.

Effective 4/14/03



ACKNOWLEDGEMENT OF RECEIPT OF  
NOTICE OF PRIVACY PRACTICES

My signature below indicates that I have received a copy of the “Notice of Privacy Practices” from Family Medicine Centers of South Carolina, LLC. I understand that my signature below allows the Practice to use or disclose my Personal Information for appropriate medical treatment, payment for services rendered, or administration of health care.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I hereby authorize the following person/s to access my personal and confidential medical records (including billing information). I understand that I may limit or revoke this authorization at any time.

Name	Relationship	Telephone #
Name	Relationship	Telephone #
Name	Relationship	Telephone #
Name	Relationship	Telephone #

Signature: \_\_\_\_\_ Date: \_\_\_\_\_