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: 1st_____ **2nd**_____ **3rd**_____

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 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**

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 herby 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: _____

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