Sumter Gastroenterology

"Your Partners in Digestive Health"

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641 W Wesmark Blvd., Sumter, SC 29150
Ph: (803) 905-6944 (905 - MYGI) **Fax**: (803) 469-3944 (469 – FXGI)

Patient Name: _____ Date of Birth: _____

Address: _____ City, State, Zip Code: _____

Home Phone: (_____)_____ ☐ Cell Phone: (_____)_____ ☐
(Check Box for Preferred Contact Number)

Social Security No.: _____ Sex: _____ Race: _____

Email: _____

Ethnicity: Hispanic Non-Hispanic Primary Language: _____

Emergency Contact Name: _____ Relationship: _____

Phone Number: (_____)_____

Primary Care Physician: _____ Referring Physician: _____

Insurance Information:

Primary Insurance :_____

Policy/ID #: _____Group #: _____

Effective Date: _____Policyholder Name:_____

Policyholder SSN:_____Policyholder DOB:_____

Relationship to Patient:_____Policyholder Employer: _____

Secondary Insurance :_____

Policy/ID # #: _____Group #: _____

Effective Date: _____Policyholder Name:_____

Policyholder SSN:_____Policyholder DOB:_____

Relationship to Patient:_____Policyholder Employer: _____

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You may give Sumter Gastroenterology written authorization to disclose your protected health information to anyone that you designate, such as a family member or personal representative. If you would like to authorize a person to receive your protected health information, please fill out the form below. You are also able to give consent for us to leave detailed information (prescription refills, results of tests, lab results, etc.) on your answering machine, voicemail, or any other party that you designate.

Patient Name: _____ Date of Birth: _____

At my request, I authorize Sumter Gastroenterology to disclose my protected health information to:

Name: _____ Phone Number: (_____) _____

Name: _____ Phone Number: (_____) _____

Name: _____ Phone Number: (_____) _____

At my request, I authorize Sumter Gastroenterology to disclose my protected health information via the following methods:

☐Leave a detailed message on my home answering machine (Phone #: (_____) _____)

☐Leave a detailed message on my work voicemail (Phone #: (_____) _____)

☐Leave a detailed message on my cell phone voicemail (Phone #: (_____) _____)

☐Fax detailed medical information (Fax #: (_____) _____)

*Authorized Signature: _____ Date: _____

PLEASE COMPLETE IF YOU WISH TO CANCEL THE ABOVE AUTHORIZATION:

I understand that I may cancel this authorization at any time by signing this notice below. However, if I cancel this authorization, I understand that the cancellation will not affect any action that Sumter Gastroenterology took prior to the receipt of this written notice of cancellation.

Signature Authorizing Cancellation: _____ *Date:* _____

Sumter Gastroenterology, LLC
Patient Financial Policies

If you have medical insurance, we will do our best to help you receive your maximum allowable benefits. In order to do this, we need you to understand our financial policies.

- If we participate with your insurance plan, co-payments and any unmet deductible amounts will be required at the time you register. We will verify your insurance benefits at the time of service.

- Some plans require prior authorization from your primary care provider in order for our physicians to see you and receive payment from your insurance plan. While we make every effort to obtain this prior to the date of service, if we do not have this authorization number, we may need to reschedule your appointment.

- If we do not participate with your insurance plan, we will file your insurance claims; however, you will be responsible for any amounts not paid by insurance. Additionally, we may collect a % of the total amount due prior to your visit.

- If you are scheduled to have a procedure performed, we will conduct a pre-operative benefits check with your primary insurance company to determine as accurately as possible what your patient responsible amount will be after insurance pays. Payment is expected as soon as possible, preferably prior to the procedure being performed.

- If you do not give us 24 hours' notice of an office or procedure appointment cancellation, you may be subject to a $50 cancellation fee.

- If you do not have insurance or for services not covered by insurance, the practice requires payment of 100% of the total charges unless payment arrangements have been made. Please speak with our Business Office Manager if you have any questions or if you need information regarding our Indigent patient care plans.

- It is our policy to send to the patient three consecutive monthly statements with any balance owed to the practice by the patient. Outstanding balances not paid in full within 90 days of the first billing statement will be placed with an outside collection agency once all attempts at collections are exhausted to include telephone calls, text messages, and emails. After that time, the patient agrees to pay the cost of collection including a reasonable attorney's fee, if this account should be placed in the hands of an attorney for collections.

- We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in making payment arrangements.

PLEASE READ THE ABOVE INFORMATION CAREFULLY BEFORE SIGNING. By signing below, I acknowledge that I have read and understand this policy. I also request that payment of authorized benefits be made to Sumter Gastroenterology, LLC. I authorize them to release medical information to my Insurance plan and its agents any information needed to determine these benefits or the benefits payable to related services.

Signature:_____ Date:_____
(Patient and/or responsible party)

Assignment of Insurance/Release and Assignment:

I hereby assign payment of authorized Medicare benefits and any other medical and/or surgical benefits, to include major medical benefits, to which I am entitled, to be paid either to me or on my behalf to Sumter Gastroenterology, LLC, for any services furnished to me by that provider. I authorize release of medical information needed to determine benefits payable for related services. This assignment will remain in effect until revoked by me in writing. A photocopy shall be valid as an original. I understand that I am financially responsible for all balances whether or not paid by insurance. I authorized assignee to release all information necessary to secure payments.

_____

Signature Date

Acknowledgement of Receipt of Notice of Privacy Practices

(To be filed in patient's medical record)

I have been presented with a copy of the Notice of Privacy Practices, detailing how my health information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding my health information. (A copy is available upon arrival)

Signed_____Date:_____

Relationship (If not signed by patient) _____

I wish to place the following restrictions on disclosure of my health information:

_____

_____

Internal Use Only

If patient/patients' representative refuses to sign acknowledgement, please document date and time the notice was presented to patient/patients' representative and sign below.
Presented on (date and time) _____

By (name and title) _____

Patient Interview Form

Patient Information

First Name:_____ Last Name:_____

Date Of Birth:_____

Email

Please check one as your preferred email for communications

☐ Personal:_____ ☐ Work:_____

Race

Select one or more

☐ White ☐ Black or African American ☐ Asian ☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander

☐ Other Race ☐ Unknown ☐ Patient declines to specify ☐ Prohibited by state law

Ethnicity

☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Patient declines to specify ☐ Prohibited by state law ☐ Unknown

Sex

☐ Male ☐ Female ☐ Other ☐ Unknown

Preferred Language

☐ English ☐ Patient declines to specify

Contact Preference

☐ Letter ☐ Email ☐ Phone ☐ Patient declines to specify Other:_____

Pharmacy

_____

Name Address Phone

Allergies

☐ Patient has no known allergies ☐ Patient has no known drug allergies

☐ Adhesive Tape ☐ Codeine Sulfate ☐ Erythromycin ☐ Penicillins ☐ Shellfish

☐ IV Contrast Dye, Iodine Containing ☐ Latex gloves ☐ Bactrim

Consent to Import Medication History

I consent to obtaining a history of my medications purchased at pharmacies.

☐ Yes ☐ No

Current Medications

☐ None

Name	Dose	How taken?

Immunizations

☐ None

☐ Influenza, seasonal, injectable When:_____

☐ Hep A When:_____

☐ Hep B When:_____

☐ Pneumovax When:_____

☐ TB skin test When:_____

Diagnostic Studies/Tests

☐ None

☐ - Colonoscopy When:_____

☐ - EGD When:_____

☐ - Flexible Sigmoidoscopy When:_____

☐ - LABS: When:_____

☐ - CT Abdomen/Pelvis When:_____

☐ - MRI Abdomen/Pelvis When:_____

☐ - ERCP When:_____

☐ - Smart Pill When:_____

☐ - Pillcam When:_____

☐ - Breath Test When:_____

☐ Other When:_____

☐ - Barium Swallow w/13mm Tablet When:_____

☐ - Modified Barium Swallow w/Speech Therapist When:_____

Previous Procedures

☐ None

☐ Gallbladder removed When:_____

☐ Appendectomy When:_____

☐ Colon resection When:_____

☐ Small Bowel Resection When:_____

☐ Exploratory Laparoscopy When:_____

☐ Gastric Bypass When:_____

☐ Gastric Lap Band When:_____

☐ Hemorrhoidectomy When:_____

☐ Hemorrhoid banding When:_____

☐ Abdominoplasty When:_____

☐ Hysterectomy-Total When:_____

☐ Hysterectomy-Partial When:_____

☐ Bilateral Tubal Ligation (BTL) When:_____

☐ Mastectomy Right/Left/Bilateral When:_____

☐ Pacemaker Insertion When:_____

☐ Defibrillator Placement When:_____

☐ Coronary Artery Bypass Graft (CABG) When:_____

☐ Abdominal aortic aneurysm (AAA) repair When:_____

☐ Heart valve replacement When:_____

☐ Cardiac Catheterization-with stent placement When:_____

☐ Cardiac Cath - without stent placement When:_____

☐ Joint Replacement When:_____

☐ Back Surgery When:_____

☐ Hernia Repair When:_____

Other:_____

Past or Present Medical Conditions

☐ None

Gastroenterology/Hepatology

☐ Colon polyp history When:_____

☐ Colon cancer When:_____

☐ Irritable Bowel Syndrome When:_____

☐ Diverticulosis When:_____

☐ Diverticulitis When:_____

☐ Crohn's Disease When:_____

☐ Ulcerative Colitis When:_____

☐ Gastroesophageal Reflux Disease (GERD) When:_____

- ☐ Barrett's Esophagus — When:
- ☐ Ulcer Disease — When:
- ☐ Hepatitis B — When:
- ☐ Hepatitis C — When:
- ☐ Fatty Liver — When:
- ☐ Cirrhosis — When:
- ☐ Celiac Disease — When:
- ☐ Bowel Obstruction — When:
- ☐ Pancreatitis — When:
- ☐ Anemia — When:
- ☐ Hemorrhoids — When:
- ☐ Hiatal Hernia — When:
- ☐ Microscopic colitis — When:
- ☐ Vitamin D Deficiency — When:
- ☐ Vitamin B12 Deficiency — When:
- Other:

Cardiology

- ☐ Coronary Artery Disease — When:
- ☐ Congestive Heart Failure — When:
- ☐ Ischemic heart disease S/P MI — When:
- ☐ High blood pressure — When:
- ☐ Atrial Fibrillation — When:
- ☐ Vascular Disease — When:
- ☐ High Cholesterol — When:
- ☐ Stroke/CVA — When:
- ☐ Transient Ischemic Attack — When:
- ☐ Valvular heart disease — When:
- ☐ Pacemaker — When:
- ☐ Coronary Artery Stents — When:
- ☐ Peripheral Artery Disease — When:
- Other:
- Other:

Pulmonology

- ☐ C.O.P.D. — When:
- ☐ Asthma — When:
- ☐ Sleep apnea- on CPAP/no CPAP — When:
- ☐ DVT — When:
- ☐ Pulmonary Embolism — When:
- ☐ Bronchitis — When:
- Other:
- Other:

Other

- ☐ Anxiety — When:
- ☐ Arthritis — When:
- ☐ Bipolar disorder — When:
- ☐ Body piercings — When:
- ☐ Breast cancer — When:
- ☐ Current pregnancy — When:
- ☐ Depression — When:
- ☐ Diabetes Mellitus, Insulin Dependent (Type 1) — When:
- ☐ Diabetes Mellitus Type 2 — When:
- ☐ Fibrositis/Fibromyalgia — When:
- ☐ Gout — When:
- ☐ HIV exposure — When:
- ☐ HIV infection — When:
- ☐ Hypothyroidism — When:
- ☐ Kidney disease — When:
- ☐ Kidney stones — When:
- ☐ Lung cancer — When:
- ☐ Ovarian Cancer — When:
- ☐ Prostate Cancer — When:
- ☐ Skin Cancer — When:
- ☐ Seizures — When:
- ☐ Tattoos — When:
- ☐ LNMP: — When:
- ☐ Migraine — When:

Social History

Marital Status

- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Separated
- ☐ Widowed
- ☐ Civil Union
- ☐ Unknown
- ☐ Other

Alcohol

- ☐ None

Type	Quantity	Number	Frequency
☐ Occasionally			
☐ Daily			

Tobacco

Smoking Status

- ☐ Current every day smoker
- ☐ Current some day smoker
- ☐ Former smoker
- ☐ Never smoker
- ☐ Smoker, current status unknown
- ☐ Light tobacco smoker
- ☐ Heavy tobacco smoker
- ☐ Unknown if ever smoked

Type	Started	Quit	Quantity	Frequency
☐ Cigarettes				
☐ Cigar				
☐ Chewing Tobacco				

Drug Use

- ☐ None

Type	Quantity	Number	Frequency
☐ IV or intranasal drugs			Times / month
☐ Recreational			Times / month
☐ Former			

Family Medical History

- ☐ No knowledge of family history

No family history of

- ☐ Celiac sprue
- ☐ Colon cancer
- ☐ Colon polyps
- ☐ Crohn's disease
- ☐ Liver disease
- ☐ Stomach cancer
- ☐ Ulcerative Colitis / IBD

	Mother	Father	Sister	Brother	Grandmother	Grandfather
Health Status						
Age/Date of Birth						
Healthy	○	○	○	○	○	○
Ill	○	○	○	○	○	○
Seriously Ill	○	○	○	○	○	○
Disabled	○	○	○	○	○	○
In Remission	○	○	○	○	○	○
Alive	○	○	○	○	○	○
Deceased/At Age	○	○	○	○	○	○
Cause of Death						
Diagnoses						
Celiac Disease	○	○	○	○	○	○
Colon cancer	○	○	○	○	○	○
Colon polyps	○	○	○	○	○	○
Crohn's disease	○	○	○	○	○	○
Gallbladder disease	○	○	○	○	○	○
Liver disease	○	○	○	○	○	○
Ulcerative colitis	○	○	○	○	○	○

Other:	○	○	○	○	○	○

Review Of Systems

Allergic/Immunologic

None	Y	N
HIV exposure	○	○
persistent infections	○	○
strong allergic reactions or urticaria	○	○

Constitutional

None	Y	N
fatigue	○	○
fever	○	○
loss of appetite	○	○
malaise	○	○
sweats	○	○
weight gain	○	○
weight loss	○	○

Eyes

None	Y	N
double vision	○	○
loss of vision	○	○
photophobia	○	○
blurred vision	○	○

ENMT

None	Y	N
difficulty swallowing	○	○
dizziness	○	○
ear pain	○	○
nasal obstruction	○	○
nose bleeds	○	○
sore throat	○	○
hearing loss	○	○

Integumentary

None	Y	N
allergies	○	○
dryness	○	○
hives	○	○
itching	○	○
jaundice	○	○
lesions	○	○
rashes	○	○

Respiratory

None	Y	N
asthma	○	○
cough	○	○
dyspnea	○	○
excessive sputum	○	○
coughing up blood	○	○
shortness of breath with activity	○	○
wheezing	○	○

Cardiovascular

None	Y	N
chest pain	○	○
Shortness of breath with activity	○	○
irregular heart beat	○	○
difficulty breathing while lying down	○	○
palpitations	○	○
swelling of legs, ankles, or feet	○	○
syncope	○	○

Gastrointestinal

None	Y	N
abdominal pain	○	○
stomach cramps	○	○
abdominal swelling	○	○
change in bowel habits	○	○
constipation	○	○
diarrhea	○	○
black colored stools	○	○
gas	○	○
heartburn	○	○
difficulty swallowing	○	○
nausea	○	○
vomiting	○	○
yellow discoloration of skin, nail beds, or eyes	○	○
rectal bleeding	○	○
stool leakage	○	○

Genitourinary

None	Y	N
dark urine	○	○
decrease in urine flow	○	○
pain with urinating	○	○
frequent urinary infections	○	○
frequent urination	○	○
hematuria	○	○
impotence	○	○
frequent urination at night	○	○
urethral discharge or incontinence	○	○
urine leakage	○	○

Musculoskeletal

None	Y	N
arthritis	○	○
back pain	○	○
gout	○	○
joint deformity	○	○
joint pain	○	○
muscle weakness	○	○
stiffness	○	○

Neurological

None	Y	N
dizziness	○	○
fainting	○	○
frequent headaches	○	○
migraine	○	○
numbness or tingling	○	○
seizures	○	○
tremors	○	○
vertigo	○	○
memory loss	○	○

Endocrine

None	Y	N
excessive thirst	○	○
hair loss	○	○
heat intolerance	○	○

Hematologic/Lymphatic

None	Y	N
bleeding gums or palpable lymph nodes	○	○
easy bruising	○	○
prolonged bleeding	○	○

Psychiatric

None	Y	N
anxiety	○	○
depression	○	○
difficulty sleeping	○	○
hallucinations	○	○
nervousness	○	○
panic attacks	○	○
paranoia	○	○

Consent to Share Data

I consent to having my medical and demographic information shared with other health care entities.

Yes No

Reminder Preference

I would like to receive preventive care and follow up care reminders.

Yes No

Reviewed with

Patient Parent Guardian Not Present

Signature

Signature Date

PLEASE BE ADVISED

IF YOU ARE PLANNING TO SCHEDULE A COLONOSCOPY OR AN UPPER ENDOSCOPY, YOUR INSURANCE WILL BE BILLED FOR THE PROFESSIONAL FEE FROM SUMTER GASTROENTEROLOGY.

A FACILITY FEE WILL ALSO BE BILLED FROM THE WESMARK AMBULATORY SURGERY CENTER OR TUOMEY HOSPITAL. YOU MAY RECEIVE A BILL FROM BOTH OFFICES.

YOU MAY ALSO RECEIVE SEPARATE BILLS FOR ANESTHESIA AND LAB SERVICES.

YOU ARE RESPONSIBLE FOR ANY UNPAID BALANCE FROM ANY OR ALL OF THE ABOVE.

THANK YOU
SUMTER GASTROENTEROLOGY, LLC

Sumter Gastroenterology, LLC
NOTICE OF PRIVACY PRACTICES
THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.
If you have any questions about this Notice please contact our Privacy Officer who is Meg Kwiecinski

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices. You may request a revised version by calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

1. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office who are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of your physician's practice.

Following are examples of the types of uses and disclosures of your protected health information that your physician's office is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with another provider. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (*e.g.*, a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

Payment: Your protected health information will be used and disclosed, as needed, to obtain payment for your health care services provided by us or by another provider. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Health Care Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, fundraising activities, and conducting or arranging for other business activities. We will share your protected health information with third party "business associates" that perform various activities (for example, billing or transcription services) for our practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. You may contact our Privacy Officer to request that these materials not be sent to you.

We may use or disclose your demographic information and the dates that you received treatment from your physician, as necessary, in order to contact you for fundraising activities supported by our office. If you do not want to receive these materials, please contact our Privacy Officer and request that these fundraising materials not be sent to you.

We may not disclose, without your written permission, your protected health information for marketing purposes. This type of disclosure will require your prior authorization.

A disclosure that constitutes the sale of your protected health information, requires your prior authorization. We may not disclose this without your written permission.

Paying Out of Pocket. We will agree to restrict the disclosure of PHI (for payment or health care operations) to a health plan when the patient paid for the service or item in question **out of pocket in full** when this request is made by the patient.

Breach Notification. An individual has a right to be notified when a breach of his or her unsecured PHI has occurred.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Agree or Object

We may use or disclose your protected health information in the following situations without your authorization or providing you the opportunity to agree or object. These situations include:

Required By Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, if required by law, of any such uses or disclosures.

Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. For example, a disclosure may be made for the purpose of preventing or controlling disease, injury or disability.

Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

Workers' Compensation: We may disclose your protected health information as authorized to comply with workers' compensation laws and other similar legally-established programs.

Inmates: We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your protected health information for the reasons covered by your written authorization. Please understand that we are unable to take back any disclosures already made with your authorization.

Other Permitted and Required Uses and Disclosures That Require Providing You the Opportunity to Agree or Object

We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician may, using professional judgement, determine whether the disclosure is in your best interest.

Others Involved in Your Health Care or Payment for your Care:

Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

2. YOUR RIGHTS

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you for so long as we maintain the protected health information. You may obtain your medical record that contains medical and billing records and any other records that your physician and the practice uses for making decisions about you. As permitted by federal or state law, we may charge you a reasonable copy fee for a copy of your records.

Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and laboratory results that are subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Officer if you have questions about access to your medical record.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or health care operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If your physician does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician. You may request a restriction by **completing a restriction form and submitting to the Privacy Officer.**

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Officer.

You may have the right to have your physician amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for so long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Officer if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or health care operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you if you authorized us to make the disclosure, for a facility directory, to family members or friends involved in your care, or for notification purposes, for national security or intelligence, to law enforcement (as provided in the privacy rule) or correctional facilities, as part of a limited data set disclosure. You have the right to receive specific information regarding these disclosures that occur after April 14, 2003. The right to receive this information is subject to certain exceptions, restrictions and limitations.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

3. COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Officer of your complaint. We will not retaliate against you for filing a complaint.

You may contact our Privacy Officer, **Meg Kwiecinski** at (803)-905-6944 for further information about the complaint process.

This notice was published and becomes effective on **August 21, 2013.**