Physicians Care

805 Montague Ave Suite A
Greenwood, SC 29649
P: 864-223-6621
F: 888-714-0583 OR 864-223-6659

*****Please initial each blank and sign and date at the bottom*****

***Please note Physicians Care only does Prior Authorizations on certain medications (Suboxone & Adderall) at this time. ***

______ I understand that on the day of my appointment all copays or deductible items must be paid before being seen or treated by the physician. I also understand that the cost of lab work collected and ran in the clinic laboratory are my responsibility and will be included in my clinic balance. If I owe a clinic balance, I must pay that balance unless a financial arrangement has been made and a payment schedule is in place. If an approved payment schedule is in place, the payment must be current before seeing the physician.

______I understand that if I do not have medical insurance that I must pay in full for the office visit on the day of the appointment.

______ I understand I must be seen for all refills and that I am required to bring **ALL MY MEDICATIONS** with me to **EVERY PHYSICIAN VISIT**.

______ I understand that I must **call 24 hours <u>before</u>** my scheduled appointment to avoid a **No-Show fee of $25.00**. If I do not call or show up for my appointment, the fee will have to be paid before an appointment will be made.

______ I understand that any medication issues or medical problems should be addressed with the doctor, not the staff therefore I will not call the staff with such issues.

______I understand that only the patient is allowed in the room with the physician unless there are extenuating circumstances due to illness of patient requiring another adult in the room. No small children are allowed in the patient exam rooms or allowed to sit in the lobby without adult supervision unless the child is the patient.

______I understand that if I am unsure if a procedure or diagnosis is covered, it is my responsibility to contact my insurance company for confirmation of coverage.

______I understand that I am responsible for contacting my insurance company and getting a formulary for medications if my insurance does not cover what I am prescribed. I am also responsible for keeping up with my own refills and letting the office know if I am in need of refills. Physicians Care does not respond to refill request made by pharmacies.

______I understand that if I am on any controlled substances, I may be required to come to monthly visits. If I take maintenance medications (blood pressure, diabetes, anxiety, ADHD) I may be required to come every 3 months to get refills on my medication.

______I understand that if I reschedule my appointment three consecutive times I may be discharged from the practice.

______I will always treat the office staff with courtesy and respect. I understand that there is a zero-tolerance policy regarding rude or harassing comments or actions to the staff. This includes but is not limited to repeated telephone calls requesting or demanding medications, and the use of profanity. Patients who exhibit inappropriate behavior will be terminated from the practice immediately.

______I understand that medications will not be replaced if they are lost, damaged, or stolen.

______I understand that all controlled substances come from a physician at Physicians Care and no other physicians or clinics.

______I understand that all my controlled substances must come from one pharmacy. Should the need to change pharmacies arise I will let my physician know immediately so they can update my records.

______I will not allow anyone else to have, use, sell, or otherwise have access to the medications. The sharing of medications with anyone is absolutely forbidden and against the law and will be grounds for immediate dismissal from the practice.

______I understand that controlled substances may be hazardous or lethal to a person who is not tolerant of their effects, especially a child, and I must keep them out of reach of such people for their own safety.

______I understand that this drug should not be stopped abruptly as withdrawal symptoms may develop.

______I will cooperate with all requests for urine drug screens, as well as any random pill/film counts of medication. Failure to comply may result in immediate discharge from the practice. I understand that urine screenings will be done at each and every visit. It is a requirement by the practice and Physicians Care will not do any prior authorizations with my insurance company for the drug screening. If my insurance does not cover the cost of the drug screening then it will be my responsibility.

______I understand that the presence of unauthorized and/or illegal substances in the screening described previously may result in prompt discharge from the practice.

______I understand that a prescription may be given early if the physician or patient will be out of town when the refill is due. The prescriptions will contain instructions to the pharmacist that the prescription may not be filled until the appropriate date.

______ I understand that if I am put on weekly visits, I am responsible for paying the cost of the weekly drug screening plus any copayments from insurance. If I am self-pay, I am responsible for paying the cost of the drug screen plus the weekly office visit cost.

______ I understand that if I am called in for a UDS Med Count I have 24 hours to comply and come in to the office to have my medication counted and to provide the office with a urine sample. I am also responsible for paying the cost of the UDS Med Count which is $25. Failure to comply could result in dismissal from the program or weekly visits at the physician's discretion.

_______ I will notify my provider if I am planning on becoming pregnant or become pregnant.

_____I understand that failure to adhere to these policies and/or failure to comply with the physician's treatment plan may result in cessation of therapy by this prescribing physician.

______ I understand that Physicians Care staff will only speak to the patient. We will not speak to anyone else about my health care due to HIPPA laws. If you have a healthcare power of attorney and can provide documentation to prove that, then we can speak to them about your healthcare.

Financial Agreement and assignment of benefits: The undersigned agrees whether he signs as an agent or as a patient that in consideration of the services to be rendered to the patient, he hereby individually guarantees payment of all charges incurred for treatment or testing in accordance with the rates and terms of Greenwood Family Practice or Physicians Care. I understand that I am responsible for any charges not covered by my insurance, Medicare, or other benefits. In some cases, my insurance company may forward payment to me directly for GFP/PC charges. I understand should I receive the payment directly; it is my obligation to forward this payment to Greenwood Family Practice, Inc. or Physicians Care. Should the account be referred to an attorney for collection, I agree to pay for GFP/PC's reasonable attorney fees and collection expenses. All delinquent accounts bear interest at the legal rate. I authorize payment of medical benefits from my insurance company/third party administrator be made directly to Greenwood Family Practice, Inc.

_______________________________ _______________________________

Patient's signature Patient printed name

____

Date

PATIENT INFORMATION

Last Name:______________________________First Name:_________________________________MI:______

DOB:____________________Sex:_______SS#__________________________________Race:______________

Address:____

City:_______________________________State:_____________________________Zip:__________________

Home Phone:__________________________________Cell Phone:____________________________________

Email Address:____

Marital Status (Circle one) Single Married Widowed Separated Divorced

Employment Status (Circle one) None Full-Time Part-Time Retired

Employer Name:_____________________________________Work Number:____________________________

Emergency Contact:__________________________________Relationship:______________________________

Phone Number:___________________________________

FINANCIALLY RESPONIBLE PARTY/ POWER OF ATTORNEY

Last Name:___________________________________First Name:_____________________________________

Relationship to Patient:____

Address:____

City:_______________________________State:_____________________________Zip:__________________

Do you have a power of Attorney? (Circle one) Yes No

If you have a POA which type? (Circle One) Durable (Both) Healthcare Financial

*****If you have a POA you are responsible for providing us with a copy of documentation to put on file with your chart.*****

INSURANCE INFORMATION

Insurance Company Name:______________________________Policy#:_______________________________

Group#:_________________Insured Name:__________________________________DOB:________________

Secondary Insurance Name:______________________________Policy#:_______________________________

Group#:_________________Insured Name:__________________________________DOB:________________

PAST MEDICAL HISTORY

Circle all that you have been diagnosed with:

Pacemaker	Headaches (Tension, Migraine)	Anemia
Heart Attack	CVA/TIA (Stroke)	Asthma
Heart Palpitations	Pneumonia	Allergic Rhinitis
Heart Murmur	Diabetes	Chronic Sinusitis
Hepatitis	IBS (irritable bowel syndrome)	Major Depressive Disorder
Peptic Ulcer	Peripheral Vascular Disease	Generalized Anxiety Disorder
Gout	HIV	Arthritis (Osteo, Rheumatoid)
Seizure	Enlarged Prostate	Dysmenorrhea (Painful Menstruation)

Other____

FAMILY MEDICAL HISTORY

*****Please indicate who in your family has any of the following.*****

Heart Disease____

Hypertension____

Stroke____

Cancer____

Glaucoma____

Diabetes____

Epilepsy____

Bleeding Disorder____

Kidney Disease____

Thyroid Disease____

Mental Illness____

HOSPITALIZATION OR SURGERY

Reason   Date

____

____

____

Continued….

____

____

____

CURRENT MEDICATIONS

____

____

____

____

____

____

DRUG ALLERGIES

____

____

____

____

HABITS

Circle all that apply:

Tobacco Type/Amount______________How Long______________Quit______________

Alcohol Type/Amount__________________________ How Long___________________

Illicit Drugs Type/Amount__________________________ How Long___________________

OTC Meds/Herbs/Vitamins

Type/Amount____ How Long___________________

Type/Amount____ How Long___________________

Type/Amount____ How Long___________________

Type/Amount____ How Long___________________

We require a credit card number to put on hold for all new patients. If you make an appointment and miss it, your card will be charged $50 for the missed appointment. We have a 24-hour cancellation policy for all appointments. If you miss three consecutive appointments, you will be discharged from the practice.

***If no credit card number is given you will not be able to schedule an initial appointment. ***

Card Type ______Visa ______Mastercard ______Discover ______Amex

Name on Card ____

Card Number ____

Card Expiration Date ____________________ CVV Number (3 digit # on back of card) __________

Billing Address____

City, State, Zip Code ____

Please read and initial the following:

I acknowledge that my card will only be charged if I miss my initial appointment in the amount of $50.

____

I acknowledge that if I need to cancel my appointment, I need to call 24 hours in advance to do so. If not, I will be charged a no-show fee.

____

I acknowledge that if I miss 3 consecutive appointments I will be discharged from the practice.

____

ASSIGNMENT OF BENEFITS, ASSIGNMENT OF RIGHTS TO PURSUE ERISA AND OTHER LEGAL AND ADMINISTRATIVE CLAIMS ASSOCIATED WITH MY HEALTH INSURANCE AND/OR HEALTH BENEFIT PLAN (INCLUDING BREACH OF FIDUCIARY DUTY) AND DESIGNATION OF AUTHORIZED REPRESENTATIVE

I hereby assign and convey directly to Greenwood Family Practice or Physicians Care or its physicians and staff, or their designated billing company, as my designated authorized representative, all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services, treatments, therapies, and/or medications rendered or provided by the above-named health care provider, regardless of its managed care network participation status. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the above-named health care provider to release all medical information necessary to process my claims. Further, I hereby authorize my plan administrator fiduciary, insurer, and/or attorney to release to the above-named health care provider all plan documents, summary benefit description, insurance policy, and/or settlement information upon written request from the above-named health care provider or its attorneys in order to claim such medical benefits.

In addition to the assignment of the medical benefits and/or insurance reimbursement above, I also assign and/or convey to the above named health care provider any legal or administrative claim or chose an action arising under any group health plan, employee benefits plan, health insurance or tortfeasor insurance concerning medical expenses incurred as a result of the medical services, treatments, therapies, and/or medications I receive from the above-named health care provider (including any right to pursue those legal or administrative claims or chose an action). This constitutes an express and knowing assignment of ERISA breach or fiduciary duty claims and other legal and/or administrative claims. I intend by this assignment and designation of authorized representative to convey to the above-named provider all my rights to claim (or place a lien on) the medical benefits related to the services, treatments, therapies, and/or medications provided by the above-named health care provider, including rights to any settlement, insurance or applicable legal or administrative remedies (including damages arising from ERISA breach of fiduciary duty claims). The assignee and/or designated representative (above-named provider) is given the right by me to (1) obtain information regarding the claim to the same extent as me; (2) submit evidence; (3) make statements about facts or law; (4) make any request including providing or receiving notice of appeal proceedings; (5) participate in any administrative and judicial actions and pursue claims or chose in action or right against any liable party, insurance company, employee benefit plan, health care benefit plan, or plan administrator. The above-named provider as my assignee and my designated authorized representative may bring suit against any such health care benefit plan, employee benefit plan, plan administrator or insurance company in my name with derivative standing at provider's expense.

Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA (health care reform legislation), ERISA, Medicare and applicable federal and state laws. A photocopy of this assignment is to be considered valid, the same as if it were the original.

I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT

____

Patient Signature

____

Date

Physicians Care

805 Montague Ave. Suite A

Greenwood, SC 29649

(864)223-6621 (P)

(864)223-6659 or 888-714-0583 (F)

Authorization to Disclose and Use Protected Health Information
(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

Patient Name:____

DOB:_________________________________ SSN#_________________________________

Authorization: I authorize the use and disclosure of the above named individual's health information as described below to be sent to Greenwood Family Practice/Physicians Care from the following organization: (This section needs the name of the doctor or clinic that currently holds your medical records)

Physician/Clinic Name:____

Address____

Phone____ Fax__________________________________

Extent of Authorization:

a. ______ I authorize the release of my complete health record (Including records relating to mental healthcare, communicable disease, HIV or AIDS and treatment of alcohol or drug abuse.
b. ______ I authorize the release of my complete health record with the exception of the following information:
   _____ Mental Health Records
   _____Communicable disease (Including HIV and AIDS)
   _____Alcohol/Drug abuse treatment

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from masking any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Effective Period:

This Authorization for release of information covers the period of healthcare form:

a. ____________ to ___________ **(OR)** b. All past, present and future periods____________

This authorization shall be in force and effect until I revoke the authorization in writing. I understand that I have the right to revoke this authorization, in writing, at any time to Physicians Care, 805 Montague Ave. Suite A, Greenwood SC 29649. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless revoked in writing this authorization will expire 1 year from the date of signing. If I have any questions about the disclosure of health information, I know I can contact Physicians Care.

I give my consent for Physicians Care to use and disclose protected health information about me to carry out treatment, payment, and health care operations. I have been given a copy of the Notice of Privacy Rights. Physicians Care reserves the right to revise their Notice of Privacy Rights at any time and can request a current copy at any time. I give Physicians Care my consent to contact me by phone (in person or by leaving a message), mail or email in reference to any items that assist the practice in carrying out treatment, payment and health operations such as appointment reminders, insurance questions and any calls pertaining to my clinical care including but not limited to test results.

____ ______________________________________

Signature of Patient Date

____ ______________________________________

Signature of Staff Witness Date

Consent to Treat Form

1. I _________________________ (patient name) give permission for **Greenwood Family Practice, Inc DBA Physicians Care** to give me medical treatment.

2. I allow **Greenwood Family Practice, Inc DBA Physicians Care** to file for insurance benefits to pay for the care I receive.

   I understand that:
   - for **Greenwood Family Practice, Inc DBA Physicians Care** will have to send my medical record information to my insurance company.
   - I must pay my share of the costs.
   - I must pay for the cost of these services if my insurance does not pay or I do not have insurance.

3. I understand:
   - I have the right to refuse any procedure or treatment.
   - I have the right to discuss all medical treatments with my clinician.

___________________________________ _________________________

Patient's Signature Date

____

Parent or Guardian Signature
(For children under 18)

____

Print Name

Greenwood Family Practice, Inc. DBA Physicians Care
805 Montague Ave. Suite A
Greenwood, SC 29649
(P) 864-223-6621 (F) 888-714-0583

Physicians Care

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISLOSED AND HOW YOU CAN GET ACCESS TO THE INFORMATION.

PLEASE REVIEW IT CAREFULLY.

This Facility is required by law to provide you with this Notice so that you will understand how we may use or share your information from your Designated Record Set. The Designated Record Set includes financial and health information referred to in this Notice as "Protected Health Information" (PHI) or simply "health information". We are required to adhere to the terms outlined in this Notice. If you have any questions about this Notice, please contact ***Christian Snead*****, Practice Manager**.

UNDERSTANDING YOUR HEALTH RECORD AND INFORMATION

Each time you are admitted to our Facility, a record of your stay is made containing health and financial information. Typically, this record contains information about your condition, the treatment we provide and payment for the treatment. We may use and/or disclose this information to:

- Plan your care and treatment
- Communicate with other health professionals involved in your care
- Document the care you receive
- Educate health professionals
- Provide information for medical research
- Provide information to public health officials
- Evaluate and improve the care we provide
- Obtain payment for the care we provide

Understanding what is in your record and how your health information is used helps you to:

- Ensure it is accurate
- Better understand who may access your health information
- Make more informed decisions when authorizing disclosure to others

HOW WE MAY USE AND DISCLOSE PROTECTED HEALTH INFORMATION ABOUT YOU

The following categories describe the ways that we use and disclose health information. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall into one of the categories.

- For Treatment: We may use or disclose health information about you to provide you with medical treatment. We may disclose health information about you to doctors, nurses, therapists or other Facility personnel who are involved in taking care of you at a Facility. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. In addition, the doctor may need to tell the dietitian if you have diabetes so that we can plan your meals. Different departments of a Facility also may share health information about you in order to coordinate your care and provide you medication, lab work and x-rays. We may also disclose health information about you to people outside the Facility who may be involved in your medical care after you leave a Facility. This may include family members, or visiting nurses to provide care in your home.
- For Payment: We may use and disclose health information about you so that the treatment and services you receive at a Facility may be billed to you, and insurance company or a third party. For example, in order to be paid, we may need to share information with your health plan about services provided to you. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.
- For Health Care Operations: We may use and disclose health information about you for our day-to-day health care operations. This is necessary to ensure that all residents receive quality care. For example, we may use health information for quality assessment and improvement activities and for developing and evaluating clinical protocols. We may also combine health information about many residents to help determine what additional services should be offered, what services should be discontinued, and whether certain new treatments are effective. Health information about you may be used by our corporate office for business development and planning, cost management analysis, insurance claims management, risk management activities, and in developing and testing information systems and programs. We may also use and disclose information for professional review, performance evaluation, and for training programs. Other aspects of health care operations that may require use and disclosure of your health information include accreditation, certification, licensing and credentialing activities, review and auditing, including compliance reviews, medical reviews, legal services and compliance programs. Your health information may be used and disclose for the business management and general activities of the Facility including resolution of internal grievances, customer service and due diligence in connection with a sale or transfer of the Facility. In limited circumstances, we may disclose your health information to another entity subject to HIPAA for its own health care operations. We may remove information that identifies you so that the health information may be used to study health care and health care

delivery without learning the identities of residents. We may disclose your age, birth date and general information about you in the Facility newsletter, or activities calendars, and to entities in the community that wish to acknowledge your birthday or commemorate your achievements on special occasions. If you are receiving therapy services, we may post your photograph and general information about your progress.

OTHER ALLOWABLE USES OF YOUR HEALTH INFORMATION

- **Business Associates:** There are some services provided in our Facility through contracts with business associates. Examples include, medical directors, outside attorneys and a copy service we use when making copies of your health record. When these services are contracted, we may disclose your health information so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.
- **Providers:** Many services provided to you, as part of your care at our Facility, are offered by participants in one of our organized healthcare arrangements. These participants include a variety of providers such as physicians (e.g., MD, DO, Podiatrist, Dentist, Optometrist), therapists (e.g., Physical therapist, Occupational therapist, Speech therapist), portable radiology units, clinical labs, hospice caregivers, pharmacies, psychologists, LCSWs, and suppliers (e.g., prosthetic, orthotics).
- **Treatment Alternatives:** We may use and disclose health information to tell you about possible treatment options or alternatives that may be of interest to you.
- **Health-Related Benefits and Services and Reminders:** We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest of you.
- **Fundraising Activities:** We may use health information about you to contact you in an effort to raise money as part of a fundraising effort. We may disclose health information to a foundation related to the Facility so that the foundation may contact you in raising money for the Facility. We will only release contact information, such as your name, address and phone number and the dates you received treatment or services at the Facility.
- **Facility Directory:** We may include information about you in the Facility directory while you are a resident. This information may include your name, location in the Facility, your general condition (e.g., fair, stable, etc.) and your religion. The directory information, except for your religion, may be disclosed to people who ask for you by name. Your religion may be given to a member of the clergy, such as a priest or rabbi, even if they don't ask for you by name. This is so your family, friends and clergy can visit you in the Facility and generally know how you are doing.
- **Individuals Involved in Your Care or Payment for Your Care:** Unless you object, we may disclose health information about you to a friend or family member who is involved in your care. We may also give information to someone who helps pay for your care. In addition, we may disclose health information about you to an entity assisting in a disaster relief effort so that you family can be notified about your condition, status and location.
- **As Required By Law:** We will disclose health information about you when required to do so by federal, state or local law.
- **To Avert a Serious Threat to Health or Safety:** We may use and disclose health information about you to prevent a serious threat to your health and safety or the health and safety of the public or another person. We would do this only to help prevent the threat.
- **Organ and Tissue Donation:** If you are an organ donor, we may disclose health information to organizations that handle organ procurement to facilitate donation and transplantation.
- **Military and Veterans:** If you are a member of the armed forces, we may disclose health information about you as required by military authorities. We may also disclose health information about foreign military personnel to the appropriate foreign military authority.
- **Research:** Under certain circumstances, we may use and disclose health information about you for research purposes. For example, a research project may involve comparing the health and recovery of all residents who received one medication to those who received another, for the same condition. All research projects, however are subject to a special approval process. This process evaluates a proposed research project and its use of health information, trying to balance the research needs with residents' need for privacy of their health information. Before we use or disclose health information for research, the project will have been approved through this research approval process. We may however, disclose health information about you to people preparing to conduct a research project so long as the health information they review does not leave a Facility.
- **Workers' Compensation:** We may disclose health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.
- **Reporting:** Federal and state laws may require or permit the Facility to disclose certain health information related to the following:
  - Public Health Risks. We may disclose health information about you for public health purposes, including:
    - Prevention or control of disease, injury or disability
    - Reporting births and deaths
    - Reporting child abuse or neglect
    - Reporting reactions to medications or problems with products
    - Notifying people of recalls of products
    - Notifying a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease
    - Notifying the appropriate government authority if we believe a resident has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law
  - Health Oversight Activities. We may disclose health information to a health oversight agency for activities authorized by law. These oversight activities may include audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.
  - Judicial and Administrative Proceedings. If you are involved in a lawsuit or a dispute, we may disclose health

information about you in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, buy only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.
  - Reporting Abuse, Neglect or Domestic Violence. Notifying the appropriate government agency if we believe a resident has been the victim of abuse, neglect or domestic violence.
- **Law Enforcement:** We may disclose health information when requested by a law enforcement official:
  - In response to a court order, subpoena, warrant, summons or similar process;
  - To identify or locate a suspect, fugitive, material witness, or missing person;
  - About you, the victim of a crime if, under certain limited circumstances, we are unable to obtain your agreement;
  - About a death we believe may be the result of criminal conduct;
  - About criminal conduct at the Facility; and
  - In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.
- **Coroners, Medical Examiners and Funeral Directors:** We may disclose medical information to a coroner or medical examiner. This may be necessary to identify a deceased person or determine the cause of death. We may also disclose medical information to funeral directors as necessary to carry out their duties.
- **National Security and Intelligence Activities:** We may disclose health information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.
- **Correctional Institution:** Should you be an inmate of a correctional institution, we may disclose to the institution or its agents health information necessary for your health and the health and safety of others.

OTHER USES OF HEALTH INFORMATION

Other uses and disclosures of health information not covered by this Notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

Although your health record is the property of the Facility, the information belongs to you. You have the following rights regarding your health information:

- **Right to Inspect and Copy:** With some exceptions, you have the right to review and copy your health information. *You must submit your request in writing to Physicians Care. We may charge a fee for the costs of copying, mailing or other supplies associated with your request.*
- **Right to Amend:** If you feel that health information in your record is incorrect or incomplete, you may ask us to amend the information. You have this right for as long as the information is kept by or for the Facility.

  You must submit your request in writing to Physicians Care. In addition, you must provide a reason for your request.

  We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

  - Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
  - Is not part of the health information kept by or for the Facility; or
  - Is accurate and complete.
- **Right to an Accounting of Disclosures:** You have the right to request an "accounting of disclosures". This is a list of certain disclosures we made of your health information, other than those made for purposes such as treatment, payment, or health care operations.

  You must submit your request in writing to Physicians Care. Your request must state a time period which may not be longer than six years from the date the request is submitted and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper or electronically). The first list you request within a twelve-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

- **Right to Request Restrictions:** You have the right to request a restriction or limitation on the health information we use or disclose about you. For example, you may request that we limit the health information we disclose to someone who is involved in your care or the payment for your care. You could ask that we not use or disclose information about a surgery you had to a family member or friend.

We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

You must submit your request in writing to Physicians Care. In your r3equest, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

- **Right to Request Alternate Communications:** You have the right to request that we communicate with you about medical matters in a confidential manner or at a specific location. For example, you may ask that we only contact you via mail to a post office box.

  You must submit your request in writing to Physicians Care. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests.

- **Right to a Paper Copy of this Notice:** You have the right to a paper copy of this Notice of Privacy Practices even if you have agreed to receive the Notice electronically. You may ask us to give you a copy of this Notice at any time.

  To obtain a paper copy of this Notice, contact Physicians Care.

CHANGES TO THIS NOTICE

We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for health information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice in the Facility and on the website. The Notice will specify the effective date on the first page, in the top right-hand corner. In addition, if material changes are made to this Notice, the Notice will contain an effective date for the revisions and copies can be obtained by contacting the Facility administrator.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the Facility or with the Secretary of the Department of Health and Human Services. To file a complain with the Facility, contact Christian Snead, Practice Manager. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

Patient Name: ____ Date: ______________________________

Please check any that apply to you today:

General, constitutional

Night Sweats __________
Recent weight change __________
Fever __________
Fatigue __________

Eyes and Vision

Wear glasses or contact lenses __________
Blurred or Double vision __________
Change in vision __________

Ears, nose, throat

Sore Throat __________
Congestion __________
Earaches or drainage __________
Loss of Hearing __________

Heart and Cardiovascular

Chest Pain __________
Palpitations __________
Swelling of feet, ankles, hands __________

Respiratory

Shortness of breath __________
Asthma or wheezing __________
Frequent coughing __________

Gastrointestinal

Blood in stool __________
Abdominal pain __________
Nausea or vomiting __________
Painful bowel movement __________
Constipation __________
Diarrhea __________

Genitourinary

Sexual difficulty __________
Burning/painful urination __________
Blood in urine __________
Incontinence or dribbling __________

Musculoskeletal

Muscle pain or cramps __________
Back pain __________
Joint Pain __________
Difficulty in walking __________

Skin and Breast

Rash or itching __________
Breast Discharge __________

Neurological

Light headed or dizzy __________
Convulsions or seizures __________
Numbness or tingling sensation __________
Tremors __________
Frequent/Recurrent headaches __________

Psychiatric

Anxiety/Nervousness __________
Depression __________
Difficulty Sleeping __________

Endocrine

Excessive thirst or urination __________
Heat or cold intolerance __________

Hematologic/Lymphatic

Easily bruise or bleed __________
Swollen Glands __________
(in neck, arm pits, groin)

Vaginal Discharge __________
Irregular/painful periods __________
Frequent urination __________