HIPAA Notice of Privacy Practices

Greenville Women's Clinic
1142 Grove RD.
Greenville S.C. 29605
(864) 232-1584
1-800-776-0082

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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) 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.

1. Uses and Disclosures of Protected Health Information

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 that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law .

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 a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to 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.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. 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.

Healthcare 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, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. 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 protected health information that is subject to law that prohibits access to protected health information.

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 healthcare 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 physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location.
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 alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. 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.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

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 contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name:_____ Signature:_____ Date:_____

Do we have your permission to:

Leave a message on your answering machine at home? ____yes ____no
Leave a message on your cell phone? ____yes ____no
Leave a message at your place of employment? ____yes ____no
Discuss your medical condition with a member(s) of your household? ____yes ____ no
If yes, Name:_____ Relationship:_____

GREENVILLE Women's CLINIC
1142 GROVE ROAD GREENVILLE, SC 29605 • (864) 232-1584

RELEASE

I, the undersigned, understand that the state of South Carolina has required that all persons receiving a first trimester abortion be tested for gonorrhea and chlamydia and **I understand I have the right to refuse these test.** Gonorrhea and chlamydia are sexually transmitted diseases and if the results of the test are positive, that information will be reported to the State Health Department as required by law. I understand that I will have to obtain treatment from the Health Department or my family physician. I release and discharge the Greenville Women's Clinic from any and all claims arising out of the requirements of having this test and any treatment needed should the tests be positive. I accept full responsibility for obtaining treatment for these conditions if I am found to be positive.

If you agree to take this test there will be **an additional $60.00 charge.**

I have read the above and **I agree** to take both tests.

_____ x_____
Witness Patient Signature

_____
Date

I have read the above and **I refuse** both tests.

_____ x_____
Witness Patient Signature

_____
Date

GREENVILLE WOMEN'S CLINIC 1142 Grove Road Greenville, South Carolina 29605
Phone (864) 232-1584 Fax (864) 232-1352

Name _____ Date of Birth _____ Age _____
Address: _____ City _____ County _____ State _____ Zip _____
Do you live within city limits: Yes _____ No _____ Phone: _____
Race: _____ Marital Status: S _____ M _____ W _____ Sep. _____ Div: _____
Social Security No. _____ Years of School Completed: _____
Notify in Emergency _____ Address : _____ Phone: _____
Referred By: _____

MEDICAL HISTORY

Date of Last Normal Menstrual Period _____ Height _____ Weight _____
Number of Previous Pregnancies _____ Number Delivered _____ Number Abortions _____ Number Miscarriages _____
Have you had a Tubal or Ectopic Pregnancy? _____
Date of your delivery: _____ Date of you last abortion: _____
Date of last Pap Smear: _____ _____ and what was the results? _____
Month Year

Syphilis Serology & Pap Smear Available At Extra Charge
YES NO

Have you ever had female trouble? _____

CHECK YES OR NO IF YOU EVER HAD THE FOLLOWING CONDITIONS: YES___ NO___

YES	NO		YES	NO		YES	NO	
___	___	ALLERGY TO LATEX?	___	___	RECENT VAG. BLEEDING AND OR ABD PAIN?	___	___	MIGRAINE HEADACHES WITH AURA
___	___	ALLERGY TO PENICILLIN?	___	___	HAD BLOOD TRANSFUSIONS?	___	___	ARE YOU A FREE BLEEDER?
___	___	OTHER MEDICINE ALLERGIES?	___	___	HEART DISEASE?	___	___	ANY ABNORMALITY OF UTERUS OR WOMB
___	___	TAKING ANY MEDICATION?	___	___	EPILEPSY?	___	___	CAPPED TEETH OF BRIDGE WORK?
___	___	REACTION TO NOVOCAINE?	___	___	HIGH BLOOD PRESSURE?	___	___	HISTORY OF ECTOPIC OR TUBAL PREGNANCY?
___	___	SURGERY?	___	___	SICKLE CELL ANEMIA?	___	___	HISTORY OF BLOOD CLOTS IN ARTERIES OR VEINS?
___	___	RECENT HOSPITALIZATION?	___	___	FAINTING?	___	___	FAM. HISTORY OF MUSCLE WASTING DISEASE?
___	___	TUBAL LIGATION? "TUBES TIED"	___	___	ASTHMA?	___	___	HISTORY OF BLOOD CLOTS IN LUNG?
___	___	CURRENTLY BREAST FEEDING?	___	___	HEPATITIS?	___	___	HISTORY OF PULMONARY EMBOLUS?
___	___	DIABETES?	___	___	ANEMIA?			
___	___	GENERAL ANESTHESIA BEFORE?	___	___	CONTACT LENS?			

EXPLAIN ANY QUESTIONS ANSWERED YES: _____

I have supplied all the answers in the foregoing and have carefully reviewed the form completed with my answers inserted, and the same are true and correct.

This _____ day of _____ 20 _____

_____ X _____
Witness Patient

PHYSICIAN NOTES

NURSE _____
NO _____

PREOPERATIVE:
GENERAL PHYSICAL CONDITION GOOD
HEART _____
LUNGS _____
RESPIRATIONS _____

ABDOMEN SOFT, NON TENDER
PELVIC ANTERIOR OR POSTERIOR
ESTIMATED DURATION OF PREGNANCY BASED ON SIZE OF UTERUS? WEEKS

POST OPERATIVE:
OPERATION SUCTION CURETTAGE
IV SEDATION OR LOCAL LIDOCAINE 1%
ESTIMATED BLOOD LOSS ML

SPECIMEN OBTAINED? APPROPRIATE OR SMALL
POST-OPERATIVE CONDITION GOOD

COMMENTS _____
DISCHARGE NOTE _____

DATE _____ _____
SIGNATURE OF SURGEON

PRE-OPERATIVE
CHART

UCG_____ Hgb_____gdl___

BP: / TEST PACK_____ Temp_____F____

P: _____ GP2 URINE STICK Rh Type_____
GLUC _____
PROT _____ Anti D _____

DATE_____ TIME CHARTED _____ CHARTED BY:_____
Pre-Medication_____ Time _____
_____
_____ Time _____
Signed: _____

Counseling:_____
Abortion and Birth Control Methods Discussed
Patient Confident with Decision

Environmental Form Sent on: **Signed:** _____

Operative_____
_____
Signed: _____

IV SEDATION:_____
NPO p MN_____
COMMENTS:_____
_____
PRE INDUCTION BP P R_____
TIME:_____
IV BUTTERFLY INTRACATH_____
HAND WRIST ANTICUBITAL_____

Stadol _____mg IV
Atropine_____ mg IV
Propofol 1%_____mg IV
N20 _____L SCCF
02_____L SCCF
Pitocin _____Units IV
Methergine .2 mg IM
Post- op BP_____P_____R_____

Continuous Pulse Oximetry Monitoring._____
_____
_____
Signed: _____

Recovery Room: Time Entered _____ Time Left_____
Misoprostol 200 mcg Yes_____ No_____
Contraception_____ **SMOKER / NON SMOKER**
Doxycycline OR Minocycline HCL 100mg- 1 capsule for 2 days to go home
Ergonovine Maleate 0.2 mg-1 tablet 3 times a day for 2 days to go home: Yes No
Tylenol 2 / 325mg tablets p.o. given Yes or No Ibuprofen 400mg tablet p.o. given Yes / No

_____
___B/P_____ B/P_____
_____
___P_____ P_____
_____
___R_____ R_____
_____
Post Operative Instructions Explained Yes No Signed_____
_____
Condition at Discharge: Good Other: Physicians Signature_____

PATIENTS' BILL OF RIGHTS

The statements below are not laws but are beliefs and values of the Greenville County Medical Society doctors who want to maintain strong, trusting-doctor relationships.

THE PATIENT HAS THE RIGHT TO:

_ A doctor who stands up for the benefit of the patient and an insurance company which respects this role.
_ Advice from his or her personal doctor, even when that advice may not agree with the opinion of the insurance company or the services listed in the insurance plan.
_ Be told his or her doctor's referral specialist-of-choice (surgery, heart, cancer are examples),even when the specialist is not a provider for the insurance plan.

PATIENTS HAVE THE RIGHT TO KNOW- BEFORE SIGNING THE INSURANCE PLAN AND SIXTY DAYS IN ADVANCE OF ANY CHANGES:

_ Limits to the medical services covered
_ Limits in their choices of doctors or hospitals
_ Any money incentives offered to the doctor by the insurance plan which might affect the care given.

THE PATIENT HAS THE RIGHT:

_ To be able to choose independent doctors rather than network or "preferred". doctors for a higher patient payment that is still affordable.
_ To coverage for the same tests, procedures and treatments as any other patient with similar problems, in the same insurance plan, as ordered by his or her doctor.
_ To confidential medical records. If releasing records to an insurance company, the patient should be able to limit what is seen by the company for any reason allowed by law.
_ To an appeals process provided by the insurance company: when medical service is denied or limited. The insurance company should be legally responsible for the decisions it makes about insured patients.
_ To be protected from loss of insurance if he or she makes a reasonable complaint against the insurance company. The patient's doctor should also be protected from loss when making or supporting a complaint for the patient.
_ To know which government agency can help when the insurance company and the patient differ about coverage of a medical service. This information should be in the plan's benefits booklet.

SIGN:_____

DATE:_____

GREENVILLE COUNTY MEDICAL SOCIETY
1395 SOUTH CHURCH STREET * GREENVILLE, S.C. 29615* (864) 370-9083

Date_____

GREENVILLE WOMEN'S CLINIC
REQUEST FOR ABORTION

NAME OF PATIENT_____
(Please Print)

I have received from the Women's Clinic a fact sheet containing detailed information on the nature and purpose of an abortion, the risks involved, and the possibility of complications. I have read the fact sheet which has been explained to any questions I may have. No guarantee or assurance has been made to me as to the results which may be obtained, and I am aware, on the basis of the fact sheet and the explanation I received, of the risks involved in an abortion and the possible complications. I understand that if there are any complications, the Greenville Women's Clinic will not be respobsible for the hospital or doctor bills.

I hereby request that **Dr. Campbell / Buffkin ,** perform an abortion upon me if he, in his medical judgement approves the performance of the abortion. If any unforeseen condition arises in the course of the abortion calling, in his judgement, for procedures in addition to or different from those contemplated. I further request and authorize him to do whatever he deems advisale to protect my health and welfare. I Consent to the administration of a local or general anesthetic.

If a health care worker comes in direct contact with a patient's blood or body fluids. I/We understand that the patient's blood may be tested for the Hepatitis B virus. Hepatitis C virus, or the HIV (human immunoderficiency virus) to determine whether or not the viruses are present, endangering the health worker (in accordance with South Carolina State title 44, chapter 29, section 44-29-230). The results of the testing will be made available to the patient.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTOOD THE ABOVE CONSENT TO AN ABORTION, THAT THE EXPLANATIONS THEREIN REFERED TO WERE MADE, THAT I HAVE TOLD MY ATTENDING PHYSICIAN THAT MY PREGNANCY COMMENCED ON _____ (DAT OF LAST MENSTRUAL PERIOD) THAT I HAVE GIVEN MY CORRECT NAME, ADDRESS, AND PHONE NUMBER, AND THAT ALL ABOVE BLANKS OR STATEMENTS REQUIRING INSERTION OR COMPLETION WERE FILLED IN.

I understant that I must have someone to drive me home.

_____ will be driving me home after the procedure.
I_____ have elected to drive myself and therefore, I release the Greenville Women's Clinic of any responsibiltiy.

Signature of Patient_____ Date _____

Signature or Parent_____ Date _____

I witness the fact that the patient received, read and said she understood the fact sheet.

Witness_____

PLEASE READ AND SIGN APPROPRIATE BLANK

I understand that failure to follow the instructions for general anesthesia concerning eating, drinking or chewing could lead to severe pneumonia or death from breathing vomitus into lungs.

I have not had anything to eat or drink since midnight prior to the day of my appointment.

Signature of Patient _____ **Date** _____