CPG Family Medicine @ Bell Street

Patient Information					
Patient name	DOB	Age	Gender – Circle one Male Female		Today's Date
Address	Home phone		Cell phone	e-mail	
City/State/Zip	SS#		Marital Status - Circle one S M D W		
Emergency Contact	Relationship		Phone # (H) (C)		

Patient Employment Information		
Employer	Contact name	Work number
Address	City/State/Zip	

Guarantor Insurance Information			
Primary Insurance	Employer	Secondary Insurance	Employer
Policy #	Group #	Policy #	Group #
Insured Name		Insured Name	
Address		Address	
City/State/Zip		City/State/Zip	
Insured DOB	Insured SS#	Insured DOB	Insured SS#

Guarantor Employment Information		
Employer	Contact name	Work number
Address	City/State/Zip	

Additional Information	
Parent/Guardian Name	Day Phone

Referral Information
How did you hear about us?

Consent for Healthcare and Release of Medical Information

I voluntarily consent to treatment at this facility by its physicians and staff. No guarantees have been made to me about the results of treatments or examination by staff at this practice. I consent to the use and disclosure of my protected health information for treatment, payment and healthcare operations. I have read this form and had the opportunity to ask questions.

Financial Responsibility and Assignment of Insurance Benefits

I authorize **CPG Family Medicine @ Bell Street** to bill my insurance company using the information I have provided to this office for payment to their **MEDICAL FACILITY**. I assign payment for the unpaid charges for certain physician services to **CPG Family Medicine @ Bell Street**. I understand I am responsible for any health insurance deductible, co-pay, and co-insurance payments. I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any medical or any other information about me to be released to the Social Security Administration or its intermediaries or carriers and any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf.

Signature of Patient or Authorized Person: ____ **Date:** __________

Acknowledgement of Receipt of Notice of Privacy Practices

I have received a copy of the Notice of Privacy Practices. I am aware that the Notice may be changed at any time and that I may request a copy of the revised notice by contacting the Office Manager.

Signature of Patient or Authorized Person: ____ **Date:** __________

FOR STAFF USE ONLY

☐ Patient refused to sign
☐ Patient refused to sign after receiving the Notice. Explanation provided that signature only documents that the Notice was received.
☐ Unable to provide NPP due to an emergency situation and the patient was not able to sign
☐ Patient refused copy of NPP but understands a copy is available upon request.

Signature of: ____ **Date:** __________

Conway Physicians Group
Family Medicine @ Bell Street

Name ____ **Date** __________________________________

Adult Health History for NEW Patients

Your answers on this form will help your health care provider get an accurate history of your medical concerns and conditions. (If you are a current patient certain areas are x-out as we have this information on file already.) Please fill in all five pages. If you cannot remember specific details, please provide your best guess. If you are uncomfortable with any question, do not answer it. Thank you!

Main reason for today's visit: ____

Other concerns: ____

REVIEW OF SYMPTOMS: Please mark the box and/or circle any persistent symptoms you have had in the past few months. Read through every section and check "no problems" if none of the symptoms apply to you. List other concerns above.

General
___Unexplained weight loss/gain
___Unexplained fatigue/weakness
___Fall asleep during day when sitting
___Fever, chills
___**No problems**

Skin
___New or change in mole
___Rash/itching
___**No problems**

Breast
___Breast lump/pain/nipple discharge
___**No problems**

Ears/Nose/Throat
___Nosebleeds, trouble swallowing
___Frequent sore throat, hoarseness
___Hearing loss/ringing in ears
___**No problems**

Eyes
___Change in vision/eye pain/redness
___**No problems**

Cardiovascular
___Chest pain/discomfort
___Palpitations (fast or irregular heartbeat)
___**No problems**

Respiratory
___Cough/wheeze
___Loud snoring/altered breathing during sleep
___Short of breath with exertion
___**No problems**

Gastrointestinal
___Heartburn / reflux / indigestion
___Blood or change in bowel movement
___Constipation
___**No problems**

Genitourinary
___Leaking urine
___Blood in urine
___Nighttime urination or increased frequency
___Discharge: penis or vagina
___Concern with sexual function
___**No problems**

Musculoskeletal
___Neck pain
___Back pain
___Muscle/joint pain
___**No problems**

Endocrine
___Heat or cold sensitivity
___**No problems**

Hematologic/Lymphatic
___Swollen glands
___Easy bruising
___**No problems**

Neurological
___Headache
___Memory Loss
___Fainting
___Dizziness
___Numbness/tingling
___Unsteady gait
___Frequent falls
___**No problems**

Allergic/Immune
___Hay fever/allergies
___Frequent infections
___**No problems**

Psychiatric
___Anxiety/stress/irritability
___Sleep problems
___Lack of concentration
___**No problems**

Woman only
___Pre-menstrual symptoms (bloating, cramps, irritability)
___Problem with menstrual periods
___Hot flashes/night sweats
___**No problems**

IMMUNIZATIONS: Check off any vaccinations you have had. Add year, if known. Check the box if you don't know the information. ☐

Tetanus (Td) _____ with Pertussis (Tdap) _____ Varicella (Chicken Pox) shot *or* illness _____ Pneumovax (pneumonia) _____ Influenza (flu shot) _____ Hepatitis A _____ Hepatitis B _____ MMR _____ Meningitis _____ Zostavax (shingles) _____ HPV _____

WOMEN'S HEALTH HISTORY:
Total number of pregnancies: _______ Number of births: _______
Date (month/day if known) of last menstrual period if you are still menstruating: _______
Age at beginning of periods (menstruation): _______
Age at end of periods (menopause): _______

MEDICATIONS: Please list (or show us your own printed record of) all prescriptions and non-prescription medications, vitamins, home remedies, birth control pills, herbs, inhalers, etc. Use the back of this form if you need more room and let us know you wrote there. **TAKE NO MEDICATIONS** ☐

Medication	**Dose (e.g. mg/pill)**	**How many times per day?**

____

____

____

____

____

____

Allergies or intolerance to medications (include type of reaction): ____

____ **NONE** ☐

HEALTH MAINTENANCE SCREENING TESTS:

Sigmoidoscopy or Colonoscopy (circle one) Date: ______________________ Polyp? ☐No ☐Yes
Eye Exam Date: ______________________

Men Only:
Prostate Exam Date:______________________

Women Only:
Mammogram Date: ______________________ Abnormal? No ☐ Yes ☐
Pap Smear Date: ______________________ Abnormal? No ☐ Yes ☐
Bone Density Test Date: ______________________ Abnormal? No ☐ Yes ☐

PERSONAL MEDICAL HISTORY: Do you have now (current) or have you had (past) any of the following conditions? **NONE** ☐

Condition	*Code*	*Current*	*Past*	*Comments*
Alcohol / Drug Abuse	305.00 / 305.90			
Allergy (Hay Fever)	477.9			
Anemia	285.9			
Anxiety	300.0			
Arthritis (Rheumatoid)	714.0			
Arthritis (Osteoarthritis)	715.90			
Asthma	493.90			
Bladder / Kidney Problems				
Blood Clot (Leg)	453.40			
Blood Clot (Lung)	415.11			
Blood Transfusion	V58.2			
Breast Lump (Benign)	611.72			
Cancer Breast	174.9			
Cancer Colon	153.9			
Cancer Other Type				
Cancer Ovarian	183.0			
Cancer Prostate	185			

Condition	*Code*	*Current*	*Past*	*Comments*
Cataracts	366.9			
Chicken Pox	052.9			
Colon Polyp	211.3			
Coronary Artery Disease	414.00			
Depression	311			
Diabetes (Adult Onset)	250.00			
Diabetes (Childhood Onset)	250.01			
Diverticulosis	562.10			
Emphysema	492.8			
Fractures (Broken Bones)				Where?
Gallbladder Disease)	574.20			
Gastroesophageal Reflux (Heartburn/GERD)	530.81			
Glaucoma	365.9			
Gout	274.9			
Gynecological Conditions (Endometriosis)	617.9			
Gynecological Conditions (Fibroids)	218.9			
Gynecological Conditions (Other)				
Heart Attack	410.9			
Hepatitis - Type A	070.1			
Hepatitis - Type B	070.30			
Hepatitis - Type C	070.51			
Hepatitis - Other	070.59			
High Blood Pressure	401.9			
High Cholesterol	272.0			
Hip Fracture	820.8			
Irritable Bowel Syndrome	564.1			
Kidney Disease / Failure	586			
Kidney Stones	592.0			
Liver Disease	573.9			
Migraine Headaches	346.90			
Osteoporosis	733.00			
Pneumonia	486			
Prostate (Enlargement)	600.00			

Condition	*Code*	*Current*	*Past*	*Comments*
Prostate (Nodules)	600.10			
Seizure / Epilepsy	780.39			
Skin Condition (Eczema)	692.9			
Skin Condition (Psoriasis)	696.1			
Skin Condition (Abnormal Moles)	238.2			
Sleep Apnea	780.57			
Stomach Ulcer	531.90			
Stroke	434.91			
Thyroid (Nodule)	241.0			
Thyroid High (Overactive) / Hyperthyroidism	242.90			
Thyroid Low (Underactive) / Hypothyroidism	244.9			
Other (List)				
Other (List)				

SURGICAL HISTORY - Please check off any procedure or surgeries. List any abnormal finding or complications. **NONE** ☐

Surgical Procedure	Code	Yes	Year	Comments
Abdominal Surgery				
Appendectomy (Appendix Removal)				
Back Surgery (Lumbar)				
Biopsy (Location)				
Breast Biopsy				Right, Left, or Both?
Breast Surgery				Right, Left, or Both?
Colonoscopy				
Coronary Bypass				
Coronary Stent				
EGD (Stomach Endoscopy)				
Cataract				
Gallbladder Removal				Laparoscopic?
Heart Surgery (Other Than Coronary Bypass)				
Hip Surgery				Right, Left, or Both?
Hysterectomy (Total, Including Ovaries)				Laparoscopic, Vaginal, or Abdominal?
Hysterectomy (Partial, Ovaries Left)				Laparoscopic, Vaginal, or Abdominal?
Knee Surgery				Right, Left, or Both?
LEEP (Cervix Surgery)				

Surgical Procedure		Code	Yes	Year	Comments
Neck Surgery					
Ovary Ligation (“Tubal”)					
Ovary Removal					Right, Left, or Both?
Vasectomy					
Sigmoidoscopy					
Sinus Surgery					
Other (List)					

Adopted – Yes No (Please Circle) If yes and you do not know your family history skip this section and continue to Other Health Issues

FAMILY HISTORY - Indicate which relative has had the following diseases (parents and siblings are most important).

Disease	Mother	Father	Sister(s)	Brother(s)	Mom’s Mom	Mom’s Dad	Dad’s Mom	Dad’s Dad	Other Relative	Comments
No significant history known										
Alcoholism / Drug Abuse										
Alzheimers										
Asthma										
Autoimmune Disease										
Bleeding or Clotting Disorder										
Cancer Breast										
Cancer Colon										
Cancer Other Type										
Cancer Ovarian										
Cancer Prostate										
Colon Polyp										
Coronary Artery Disease (e.g., Heart Attack, Angina)										
Depression/Suicide/Anxiety										
Diabetes (Childhood Onset)										
Diabetes (Adult Onset)										

Emphysema (COPD)										
Genetic Disorder (Explain)										
Glaucoma										
Heart Disease (CHF)										
Heart Disease (Other)										
Hepatitis B or C										
High Blood Pressure - Hypertension										
HIgh Cholesterol										
Hip Fracture										
Hypothyroidism / Thyroid Disease										
Kidney Disease										
Kidney stones										
Macular Degeneration										
Migraine Headaches										
Osteoporosis										
Other (List)										

RACE:
Please Check One:

☐ American Indian ☐ Black or African American ☐ Native Hawaiian or Pacific Islander

☐ Asian ☐ White

PHARMACY:
LOCAL: NAME: ____ DATE: __________________________________

MAIL ORDER: NAME: ____ DATE: __________________________________

SOCIAL HISTORY:

Occupation (or Prior Occupation): ____
Retired/Unemployed/Leave of Absence/Disabled (Circle One)

Employer: ____Years of Education or Highest Degree: _______________

Marital Status: Single, Partner, Married, Divorced, Widowed, Other: ____________________

Spouse/Partner’s Name: ____Number of Children: ______ Ages if under 18: _______________

Number of Grandchildren: ___________ Number of Great Grandchildren: ___________

Who Lives at Home with You? ____

Leisure Activities, Group Involvement, Religion, Volunteer Work, Recent Travel: ____

____

LIST OF ALL CURRENT PHYSICIANS: (more lines available on next page)

OTHER HEALTH ISSUES:

Tobacco Use

Smoke Cigarettes: Never ☐ No ☐ Yes ☐
(If you never smoked cigarettes, please go to alcohol use question now)

Quit Date: ___________ How Many Years Did You Smoke? ____________

Current Smoker: Packs/Day: ________ # of Years:

Other Tobacco: Pipe? ☐ Cigar? ☐ Snuff? ☐ Chew? ☐

Alcohol Use

Do You Drink Alcohol? No ☐ Yes ☐

# of Drinks/Week: __________________ Beer ☐ Wine ☐ Liquor ☐

Drug Use

Do You Use Marijuana or Recreational Drugs? Yes ☐ No ☐
Have You Ever Used Needles to Inject Drugs? Yes ☐ No ☐

Signature:_____ ____ Date:____
Circle one: patient or legal representative

CPG Family Medicine @ Bell Street

Compound Authorization for Release of Information

Name of Patient ______________________________ Date of Birth ______________

CPG Family Medicine @ Bell Street is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

Person Authorized to Receive Protected Health Information About You:
Check each person/entity that you approve to receive information.

☐ **Spouse** (provide name): ______________________________
Authorized to receive information regarding:
- ○ Financial Information
- ○ Medical Information

☐ **Parent** (provide name)**:** ______________________________
Authorized to receive information regarding:
- ○ Financial Information
- ○ Medical Information

☐ **Employer** (provide name): ______________________________
Authorized to receive information regarding:
- ○ Appointment absentee information

☐ **School** (provide name): ______________________________
Authorized to receive information regarding:
- ○ Appointment absentee information

☐ **Referring Physician** (provide name): ______________________________
Authorized to receive information regarding:
- ○ Medical Information
- ○ Appointment Information

☐ **Other** (provide name): ______________________________
Authorized to receive information regarding:
- ○ Financial Information
- ○ Medical Information

I give authorization for the release of protected health information on voice mail.
☐ Yes ☐ No
Authorized to receive information regarding:
- ○ Results of tests that are normal (including but not limited to lab and x-rays)
- ○ Appointment Information
- ○ Prescription Refill Information
- ○ Other Information as follows: ______________________________

Rights of the Patient

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending a written notification to **CPG Family Medicine @ Bell Street**. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.

______________________________ Date ______________
Signature of Patient or Personal Representative
Description of Personal Representative's Authority (attach necessary documentation)
____

CONWAY PHYSICIANS GROUP

NOTICE OF PRIVACY PRACTICES

This Notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully. The privacy of your health information is important to us.

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

We are required by law to follow the practices described in this Notice. We may change the terms of this Notice at any time. The new Notice will be effective for all protected health information we maintain at that time including health information we created or received before we made the changes.

You may obtain a copy of our Notice of Privacy Practices at any time by calling our office or requesting one at your next appointment.

Uses and Disclosures of Health Information

Treatment: We will use and disclose your health information to provide, coordinate and manage health care and related services for you. For example we will disclose information to a specialist to whom you have been referred to ensure the provider has enough information to diagnose and/or treat you. We may also disclose information to a laboratory that, at our request, becomes involved in your treatment.

Payment: We may use and disclose your information to obtain payment for services we provided to you. For example we will send the necessary information to your health or dental insurance company to obtain payment for the treatment provided.

Healthcare Operations: We will use and disclose your health information to conduct the business activities of this office. These activities include, but are not limited to, quality assessment and improvement activities, review of the performance and qualifications of employees, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

We may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting room when we are ready to begin your treatment. We may use and disclose Protected Health Information to contact you to remind you that you have an appointment for medical care, or to contact you to tell you about possible treatment options or alternatives or health related benefits and services that may be of interest to you.

We will share your protected health information with business associates that perform specific functions for our practice such as billing. When a business arrangement of this type requires the use of your information, we will have a written contract with the third party to protect the privacy of your protected health information.

Others Involved in Your Health Care: We must disclose your health information to you as described in the Patient Rights section of this Notice. We may disclose your health information to a family member or other person to the extent necessary to help with your health care or with payment for your health care, but only if you agree. If we determine it is in your best interest based on our professional judgement or experience with common practices, we may allow another person to pick up filled prescriptions, medical supplies, x-rays or other forms of health information.

We may use or disclose protected health information to notify or assist in notifying a family member, a personal representative or any other person responsible for your care of your location, your general condition or death. If you are present prior to the use or disclosure of your protected health information, we will provide you with the opportunity to object to such uses or disclosures. 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 members or others involved in your health care.

Emergencies: In the event of your incapacity or in emergency circumstances, we may use or disclose your protected health information to treat 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, at any time, in writing, except to the extent that an action has already been taken in reliance on the authorization.

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

We may use or disclose your protected health information in the following situations without your consent or authorization. These situations include:

Required By Law: We may use or disclose your protected health information to the extent that law requires the use or disclosure. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law.

We must make disclosures to you and, when required, to the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of the Privacy Rule, Section 164.500 et.seq.

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. The disclosure will be made for the purpose of controlling disease, injury or disability. Additionally, 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.

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.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of the practice, and (6) medical emergency (not on the Practice's premises) and it is likely that a crime has occurred.

Military Activity and National Security: When the appropriate conditions apply, we may disclose, to military authorities, protected health information of individuals who are Armed Forces personnel. 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.

Minors: We may disclose the Protected Health Information of minor children to their parents or guardians unless such disclosure is otherwise prohibited by law.

Business Associates: We may disclose Protected Health Information to our business associates who perform functions on our behalf or provide us with services if the Protected Health Information is necessary for those functions or services. All of our business associates are obligated, under contract with us, to protect the privacy and security of your health information.

Data Breach Notification Purposes: We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information.

Your Rights

Your rights with respect to your protected health information and how you may exercise those rights are outlined below.

You have a right to obtain a copy and/or inspect your health information: Health information includes treatment records, billing records and any other records used by us to make decision about your treatment. You may obtain a form from our office to request access. A reasonable cost-based fee will be charged for expenses such as staff time, copies and postage. Contact us as indicated at the end of this Notice to obtain information about our fees or if you have any questions about your access.

Right to an Electronic Copy of Electronic Medical Records: If your Protected Health Information is maintained in an electronic format, you have the right to request than an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your Protected Health Information in the form or format you request, if it is readily producible in such format. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

You have a right to request a restriction on the use and disclosure of your protected health information: You may ask us not to use or disclose some part of your protected health information for the purposes of treatment, payment or operations. You may also request that we not disclose some part of your information to family and others who may be involved in your care or for notification purposes as otherwise described in this Notice. We are not required to agree to the restrictions but if we do, we are obligated to abide by the agreement except in cases of emergency. You may request a restriction by sending your request in writing to our Privacy Contact.

You have a right to request confidential communications: You have the right to request that we communicate with you only in certain ways to preserve your privacy. For example, you may request that we contact you by mail at a specific address or call you only at your cell number. You must make any such request in writing and you must specify how or where we are to contact you. We will accommodate all reasonable requests. We will not request an explanation from you as to the basis for the request.

You may have the right to request an amendment to your protected health information. You may request that we amend protected health information about you. Your request must be in writing with an explanation as to why the information should be amended. 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. 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. This right applies to disclosures made by our Business Associates or us. It excludes disclosures for treatment, payment or healthcare operations as described in this Notice of Privacy Practices, to you, to family members or friends involved in your care, for notification purposes or as a result of an authorization signed by you. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003 for up to the previous 6 years. You may request a shorter timeframe. The right to receive this information is subject to certain exceptions, restrictions and limitations. If you request an accounting more than once in a 12 month period, we will charge you a reasonable cost-based fee for responding to the additional request.

Right to Get Notice of a Breach: You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

Out of Pocket Payments: If you paid out of pocket (or in other words, you have requested that we not bill your health plan) in full for a specific items or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

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.

The Adult Consent Act & Disclosure of Health Information to Designated Individuals (S.117): "DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHEN?"

NO___________ YES (WHEN) __________________

You may revoke or modify this specific authorization and the revocation or modification must be in writing.

This laws defines treatment as "the broad range of emergency, outpatient, intermediate, and inpatient services and care that may be extended to a patient to diagnose and treat a human disease, ailment, defect, abnormality, or complaint, whether of physical or mental origin. Treatment includes, but is not limited to, psychiatric, psychological, substance abuse, and counseling services."

The provider who discloses this information in good faith in accordance with the designation, the provider will be immune from civil and clinical liability, and disciplinary sanctions. While we assume most hospitals already have forms which comply with this law, you are encouraged to review all of your information forms, and add this required language if needed. This law becomes effective January 1, 2014.

How to Exercise Your Rights

To exercise your rights described in this Notice, send your request, in writing, to our Privacy Officer at the address listed at the beginning of this notice. We may ask you to fill out a form that we will supply. To exercise your right to inspect and copy your Protected Health Information, you may also contact your Physician's office directly.

Changes to this Notice

We reserve the right to change this Notice. We reserve the right to make the changed Notice effective for Protected Health Information we already have as well as for any Protected Health Information we create or receive in the future. A copy of our current Notice is posted in our offices and on our website.

Questions and Complaints

If you have any questions, concerns or want more information about our privacy practices please contact us using the information below.
If you are concerned that we may have violated your privacy rights or you disagree with a decision we have made regarding your access to your health information or any other request you have made in the exercise of your rights, you may send your complaint to us using the information below. You may also submit a written complaint to the Secretary of Health and Human Services. Contact us for the address of the Department of Health and Human Services.
We support your right to the privacy of your health information and we will not retaliate against you in any way for filing a complaint.

Contact our administrative office:

Contact Office or Official Warren C. Ratley, MBA, FACMPE, President

Phone 843-234-5139 **Fax** 843-234-6822

Address 300 Singleton Ridge Road
P.O. Box 829
Conway, SC 29528-0829

This notice was published and becomes effective on September 1, 2015.