Notice of Privacy Practices
South Main Clinic LLC

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. Personally identifiable information about your health, your health care, and your payment for health care is called Protected Health Information. We must safeguard your Protected Health Information and give you this Notice about our privacy practices that explains how, when and why we may use or disclose your Protected Health Information. Except in the situations set out in the Notice, we must use or disclose only the minimum necessary Protected Health Information to carry out the use or disclosure.
We must follow the practices described in this Notice, but we can change our privacy practices and the terms of this Notice at any time. If we revise the Notice, you may read the new version of the Notice of Privacy Practices on our website at www.southmainky.com. You also may ask for a copy of the Notice by calling us at 270.927.4488 and asking us to mail you a copy or by asking for a copy at your next appointment.

Uses and Disclosures of Your Protected Health Information That Do Not Require Your Consent
We may use and disclose your Protected Health Information as follows without your permission:
For treatment purposes. We may disclose your health information to doctors, nurses and others who provide your health care. For example, your information may be shared with people performing lab work or x-rays.
To obtain payment. We may disclose your health information in order to collect payment for your health care. For instance, we may release information to your insurance company.
For health care operations. We may use or disclose your health information in order to perform business functions like employee evaluations and improving the service we provide. We may disclose your information to students training with us. We may use your information to contact you to remind you of your appointment or to call you by name in the waiting room when your doctor is ready to see you.
When required by law. We may be required to disclose your Protected Health Information to law enforcement officers, courts or government agencies. For example, we may have to report abuse, neglect or certain physical injuries.
For public health activities. We may be required to report your health information to government agencies to prevent or control disease or injury. We also may have to report work-related illnesses and injuries to your employer so that your workplace may be monitored for safety.
For health oversight activities. We may be required to disclose your health information to government agencies so that they can monitor or license health care providers such as doctors and nurses.
For activities related to death. We may be required to disclose your health information to coroners, medical examiners and funeral directors so that they can carry out duties related to your death, such as determining the cause of death or preparing your body for burial. We also may disclose your information to those involved with locating, storing or transplanting donor organs or tissue.
For studies. In order to serve our patient community, we may use or disclose your health information for research studies, but only after that use is approved by an appropriate review board or a special privacy board. In most cases, your information will be used for studies only with your permission.
To avert a threat to health or safety. In order to avoid a serious threat to health or safety, we may disclose health information to law enforcement officers or other persons who might prevent or lessen that threat.
For specific government functions. In certain situations, we may disclose health information of military officers and veterans, to correctional facilities, to government benefit programs, and for national security reasons.
For workers' compensation purposes. We may disclose your health information to government authorities under workers' compensation laws.
For fundraising purposes. We may use certain information (such as demographic information, dates of services, department of service, treating physicians, and outcomes) to send fundraising communications to you. However, you may opt out of receiving any such communications by contacting our Privacy Officer (listed below) and your decision to opt-out will have no impact on your treatment.

Uses and Disclosures of Your Protected Health Information That Offer You an Opportunity to Object
In the following situations, we may disclose some of your Protected Health Information if we first inform you about the disclosure and you do not object:
In patient directories. Your name, location and general health condition may be listed in our patient directory for disclosure to callers or visitors who ask for you by name. Additionally, your religion may be shared with clergy.
To your family, friends or others involved in your care. We may share with these people information related to their involvement in your care or information to notify them as to your location or general condition. We may release your health information to organizations handling disaster relief efforts.

Uses and Disclosures of Your Protected Health Information That Require Your Consent

The following uses and disclosures of your Protected Health Information will be made only with your written permission, which you may withdraw at any time:

For research purposes. In order to serve our patient community, we may want to use your health information in research studies. For example, researchers may want to see whether your treatment cured your illness. In such an instance, we will ask you to complete a form allowing us to use or disclose your information for research purposes. Completion of this form is completely voluntary and will have no effect on your treatment.

For marketing purposes. Without your permission, we will not send you mail or call you on the telephone in order to urge you to use a particular product or service, unless such a mailing or call is part of your treatment. Additionally, without your permission we will not sell or otherwise disclose your Protected Health Information to any person or company seeking to market its products or services to you.

Of psychotherapy notes. Without your permission, we will not use or disclose notes in which your doctor describes or analyzes a counseling session in which you participated, unless the use or disclosure is for on-site student training, for disclosure required by a court order, or for the sole use of the doctor who took the notes.

For any other purposes not described in this Notice. Without your permission, we will not use or disclose your health information under any circumstances that are not described in this Notice.

Your Rights Regarding Your Protected Health Information

You have the following rights related to your Protected Health Information:

To inspect and request a copy of your Protected Health Information. You may look at and obtain a copy of your Protected Health Information in most cases. You may not view or copy psychotherapy notes, information collected for use in a legal or government action, and information which you cannot access by law. If we use or maintain the requested information electronically, you may request that information in electronic format.

To request that we correct your Protected Health Information. If you think that there is a mistake or a gap in our file of your health information, you may ask us in writing to correct the file. We may deny your request if we find that the file is correct and complete, not created by us, or not allowed to be disclosed. If we deny your request, we will explain our reasons for the denial and your rights to have the request and denial and your written response added to your file. If we approve your request, we will change the file, report that change to you, and tell others that need to know about the change in your file.

To request a restriction on the use or disclosure of your Protected Health Information. You may ask us to limit how we use or disclose your information, but we generally do not have to agree to your request. An exception is that we must agree to a request not to send Protected Health Information to a health plan for purposes of payment or health care operations if you have paid in full for the related product or service. If we agree to all or part of your request, we will put our agreement in writing and obey it except in emergency situations. We cannot limit uses or disclosures that are required by law.

To request confidential communication methods. You may ask that we contact you at a certain address or in a certain way. We must agree to your request as long as it is reasonably easy for us to do so.

To find out what disclosures have been made. You may get a list describing when, to whom, why, and what of your Protected Health Information has been disclosed during the past six years. We must respond to your request within sixty days of receiving it. We will only charge you for the list if you request more than one list per year. The list will not include disclosures made to you or for purposes of treatment, payment, health care operations if we do not use electronic health records, our patient directory, national security, law enforcement, and certain health oversight activities.

To receive notice if your records have been breached. South Main Clinic LLC will notify you if there has been an acquisition, access, use or disclosure of your Protected Health Information in a manner not allowed under the law and which we are required by law to report to you., We will review any suspected breach to determine the appropriate response under the circumstances.

To obtain a paper copy of this Notice. Upon your request, we will give you a paper copy of this Notice.

If you have any questions about these rights, please contact us.

How to Complain about Our Privacy Practices

If you think we may have violated your privacy rights, or if you disagree with a decision we made about your Protected Health Information, you may file a complaint with our Privacy Officer by writing to South Main Clinic, Attn: Health Information Officer, 1913 South Main Street, Madisonville, KY 42431.

You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services by writing to 200 Independence Avenue SW, Washington, D.C. 20201 or by calling 1-877-696-6775.

We will take no action against you if you make a complaint to either or both of these persons.

How to Receive More Information About our Privacy Practices

If you have questions about this Notice or about our privacy practices, please contact our Privacy Officer at 270.297.4488 This Notice is effective on December 11, 2019.

We are required by law to maintain the privacy of protected health information 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.

This signature is only acknowledgement that you have received this notice of our Privacy Practices.

Printed Name:_____

Signature:_____ Date:_____

South Main Clinic believes in your right to choose your health care providers including your physician, nurse practitioner, pharmacy, lab, imaging and any other services. If you have any concerns or questions about your rights, please contact the Clinic Director at 270.297.4488.

The following individuals may have access to my personal health information without restriction unless otherwise noted. I understand that I may add or remove anyone with access or their restrictions in writing at any time.

Name:_____ Restrictions:_____
Name:_____ Restrictions:_____
Name:_____ Restrictions:_____

Consent

I authorize the providers of South Main Clinic to provide myself (or dependent) with reasonable and proper medical care.

I authorize my health insurance company or third-party payer to pay my insurance benefits directly to South Main Clinic.

I authorize South Main Clinic to release any information required to process my insurance claim.

I understand that I am ultimately financially responsible for any balance remaining on the account after insurance has paid or total charges even if the insurance is pending or has denied.

The above information is true to the best of my knowledge.

_____ Date: _____
Patient/Responsible Party Signature

This document may contain Protected Health Information (PHI) or other private information. If the completed form is delivered in any way other than hand delivered or faxed, the information may be viewed by unintended persons. We strongly recommend that this document be hand delivered or faxed to avoid this possibility. We cannot guarantee the protection of your information unless it is secured by you in this way. South Main Clinic is not responsible for the protection of this information before it is received by us. If you have any questions, feel free to call us at 270.927.4488. This document may be securely faxed to 270.263.4031.

SOUTH MAIN CLINIC, LLC

Adult Intake History

Name: _____
(Last) (First) (Middle)

Date of birth: _____ Social Security Number: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Email:_____Phone_____

Race/Ethnicity: White ☐ African American ☐ Hispanic ☐ Other ☐ _____

Gender: Male ☐ Female ☐ Other _____

Sexual Orientation: heterosexual ☐ homosexual ☐ Other ☐ _____

Marital Status: Married☐ Divorced ☐ Single☐ Widowed ☐

Spouse's Name:_____Referred to this office by:_____

Emergency Contact

Name: _____Phone Number: _____

Relationship: _____Email:_____

Preferred Pharmacy (Name & City): _____

Current/Previous Provider Name:_____

Address: _____

Phone Number:_____ Fax Number:_____

Employer Information

Employer: _____ Employer Phone Number: _____

Occupation: _____

Please present your insurance card and ID card with this New Patient Form.

___ Patient is the Responsible Party, *if not complete the following*:

Responsible Party:_____Phone:_____

Relationship to Patient:_____ Email:_____

Date of birth: _____Social Security Number: _____

__Address is same as Patient, if not complete the following:

Address: _____

City: _____ State: _____ Zip Code: _____

Have you or your family traveled out of the country in the last 14 days ☐ Yes ☐ No

Have you or a family member had a fever of 99 or above in the last 14 days? ☐ Yes ☐ No

Have you or your family traveled to New York, Florida or Texas in the last 14 days? ☐ Yes ☐ No

Have you or your family been around anyone that has been diagnosed with COVID-19? ☐ Yes ☐ No

Have you or anyone in your family been experiencing the following symptoms:

Cough, Shortness of Air, Persistent Pain, Chest Pain, Face or lips turning blue? ☐ Yes ☐ No

Adult Intake History

It is important that these forms be as complete as possible in order to provide the best patient care. Additionally, missing information may cause third-parties to determine the visit as non-reimbursable if certain data is missing, including copies of current insurance cards, etc. The clinic may decline to see any patient where this intake information is incomplete.

Current Medications and Directions

Medication & Strength	Directions	Medication & Strength	Directions

Allergies

Drug/Food	Reaction	Drug/Food	Reaction

☐ **DENIES TOBACCO/ALCOHOL/CAFFEINE USE**

Tobacco Use:	☐ Cigarettes	Packs per Day:	How Long:
	☐ Snuff/Chew	Times per Day:	How Long:
Alcohol Use:	☐ Beer	Beers per Day:	How Long:
	☐ Liquor	Drinks per Day:	How Long:
Caffeine Use:	☐ Coffee/Soda	Drinks per Day:	How Long:

SURGICAL HISTORY

☐ NO SIGNIFICANT SURGICAL HISTORY

☐ Adenoid/Tonsil	☐ Ear Tubes	☐ Pacemaker
☐ Appendix	☐ Fracture Repair	☐ Tubal ligation
☐ Breast Lumpectomy	☐ Gallbladder	☐ Stent
☐ C-Section	☐ Hernia Repair	☐ Vasectomy
☐ CABG	☐ Hip Surgery	☐
☐ Cardiac Cath.	☐ Hysterectomy	
☐ Cardiac Endarterectomy	☐ Mastectomy	
☐ Cataract	☐ Pacemaker	
☐ Circumcision	☐ Tubal Ligation	

PAST MEDICAL HISTORY

☐ NO SIGNIFICANT PAST MEDICAL HX REPORTED

☐ AIDS	☐ Diabetes: ☐ Type I ☐ Type II	☐ Lupus
☐ Anemia	☐ Diverticulitis	☐ Mental Health Issues
☐ Arthritis ☐ OA ☐ RA	☐ Emphysema/Chronic Bronchitis	☐ Mitral Valve Prolapse
☐ Asthma	☐ GERD	☐ Neurologic Problem
☐ Atrial Fibrillation	☐ Gout	☐ Osteoporosis
☐ Auto Immune Disorder	☐ Headache: ☐ Tension ☐ Migraine	☐ Seasonal Allergies
☐ Back Pain	☐ Heart Attack	☐ Seizures
☐ Blood Clot	☐ Heart Disease	☐ Sleep Apnea
☐ Blood Disorder	☐ Hepatitis ☐ A ☐ B ☐ C	☐ Stroke
☐ Cancer:	☐ High Blood Pressure	☐ Thyroid Disease
☐ CHF	☐ High Cholesterol	☐ Tuberculosis
☐ COPD	☐ Kidney Disease	☐
☐ Depression/Anxiety	☐ Liver Disease	☐

Last Colonoscopy Date:_____ **Last Dexa Scan Date:**_____

Last Mammogram Date:_____ **Last Pap Smear Date:**_____

Other Medical problems not listed above:

_____

FAMILY HISTORY

	Mother	Father	Siblings	Family
Alive	☐	☐	☐	☐
Anxiety/Depression	☐	☐	☐	☐
Cancer	☐	☐	☐	☐
Cholesterol	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Heart Attack	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐
Stroke	☐	☐	☐	☐
Thyroid	☐	☐	☐	☐

Over the **last 2 weeks**, how often have you been bothered by any of the following problems?

	Not At All	Several Days	More than ½ days	Nearly Every Day
Little interest or pleasure in doing things				
Feeling down, depressed or hopeless				
Trouble falling or staying asleep/Sleeping too much				
Feeling tired or having little energy				
Poor appetite or overeating				
Feeling bad about yourself or that you are a failure or have let yourself or your family down				
Trouble concentrating on things such as reading the paper or watching television				
Moving or speaking so slowly other people noticed or the opposite, being fidgety or restless				
Thought that you would be better off dead or hurting yourself				
How difficult have these problems made it for you to do your work, take care of things at home or get along with others?				

Your Signature_____ Date: _____

Please print your name: _____