Family Medicine of SayeBrook

Patient Name: _____

Account #: _____

Patient Information

Date_____ Social Security # _____

Last Name_____ First Name_____ MI___

Mailing Address_____ Apt # _____

City_____ State_____ Zip _____

Physical Address_____ Apt #_____ Zip _____

Email Address _____

Home Phone ( )_____ Cell Phone ( )_____

Birthday_____ Sex_____ Marital Status _____

Employer_____ Address _____

Work Phone ( )_____ Employment Status _____

Race	Ethnicity	Primary Language	Preferred Method of contact
☐ Asian	☐ Hispanic/Latino	☐ English	
☐ Black/African American	☐ Not Hispanic/Latino	☐ French	☐ Home Phone
☐ Prefer not to answer	☐ Prefer not to answer	☐ Spanish	☐ Cell phone
☐ White		☐ Other	
☐ Other _____			

Primary Insurance_____ Secondary Insurance _____

***Please present your insurance card and valid picture ID to the receptionist.*

Insured/Responsible Party

Relationship to patient_____ SS # _____

Last Name_____ First Name_____ MI

Mailing Address_____ Apt #_____ Zip _____

Home Phone ( )_____ Cell Phone ( )_____

Birthday_____ Sex_____ Employer _____

Emergency Contact

*Name*_____ *Relationship* _____

*Home Phone*_____ *Work Phone*_____ *Cell Phone* _____

How did you hear about this practice? _____

Family Medicine of SayeBrook

Patient Name: _____

Account #: _____

Office Copy

Patient Responsibility

OFFICE HOURS – Monday – Thursday 8-5 (closed for lunch 12-1) Friday 8-12. Appointments preferred. Same day appointments should be available if you call before 10:00 a.m. on the day you wish to be seen. Our office will attempt to contact you about your appointment two days prior. *If you fail to notify us at least 12 hours prior to your scheduled office visit and do not keep your appointment, you will be billed a $20 no show fee.* Your insurance company will not pay this fee and you will be responsible.

FINANCIAL POLICY – Payment is expected at the time of your office visit. We accept VISA, MasterCard, Discover, American Express, Debit Card, & Cash. Personal checks may be accepted with valid South Carolina Drivers License upon approval from a check verification service. Keep in mind that your insurance policy is a contract between you and your insurance company. As a service to you, we will file your insurance. ** If your insurance is not one we participate with then you will be responsible for payment in full at the time of service. If we later receive a check from your insurer, we will refund any overpayment to you. ** If your insurance company is one we participate with you may pay your estimated portion at the time of service. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment. If we later receive a check from your insurer, we will refund any overpayment to you. If you are a eligible individual enrolled in the Qualified Medicare Beneficiary (QBM) Program, please notify the receptionist prior to your visit.
**Not all insurance plans cover all services. In the event your insurance plan determines a service to be "not covered", you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.
There will be a $30 fee for all returned checks. Balances over 90 days old may be subject to collections.

SEPARATE BILLING – Certain laboratory services are processed and billed by Laboratory Corporation of America (Lab Corp). Therefore, for all pathology/cytology tests and certain lab tests, you will receive a separate bill for specimens sent to the above referenced laboratory.

DISABILITY / FMLA / LEAVE OF ABSENCE FORMS – There will be a minimum $20 charge for form completion. This fee must be paid in advance. Our office requires seven to ten business days to complete the forms. Some cases may require an office visit with the doctor.

AFTER HOURS / WEEKEND CALLS – Should you need to speak to a clinical staff member after hours call our office at (843) 293-8850 and listen carefully to the recorded message. *If it is a life-threatening emergency, call 911.*

PRESCRIPTION REFILLS – If you need a refill on your prescription(s) please visit the patient portal or contact us directly. This includes mail order pharmacy refills or transfers of prescriptions from one pharmacy to another. Please allow 24 hours to process.

RETURN CALLS – All patient calls will be responded to in a timely manner, but some may take 24 hours before you receive a response. If you call by 3:00 P.M., every attempt will be made to have an answer to your question before the end of the day. Please leave a phone number(s) where you can be reached during the day. Return calls are responded to in this manner so that our physicians are not interrupted during that day's scheduled patient visits.

HEALTH INFORMATION – Clinical summaries are available upon request in the patient portal or the office.

By my signature, I understand that I am directly responsible to this office for all charges, and that I must provide a valid picture ID, current insurance, and health history information. I also understand that all co-payments co-insurance, and payments for services not covered by insurance are due the date service are rendered. I request that payment of authorized Medicare and other insurance benefits be made on my behalf to Family Medicine of SayeBrook, LLC for any administration and its agents any information needed to determine these benefits payable to related services. I authorize you to release to HCFA and any other carrier and its agent any information needed to file and process my claim.

I authorize the physicians of Family Medicine of SayeBrook, LLC, his/her staff to perform and do hereby consent to such medical treatment as he/she feels necessary, including diagnostic procedures, medical exams, and treatment as he/she feels necessary. I acknowledge that no guarantees have been made to me as to the result of any procedure, treatment, or examination.
I have read and understand the practices policies and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time.

Patient Signature_____ Date _____

Patient Name Printed_____ Witness _____

Family Medicine of SayeBrook

Patient Name: _____

Account #: _____

Date of Birth: _____

Compound Authorization for Release of Information

Family Medicine of SayeBrook, LLC 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: Please check each person/entity that you approve to receive information.

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

☐ Parent/Other (provide name or names): _____
Authorized to receive information regarding:
- ☐ Financial Information
- ☐ Medical Information

☐ Employer and/or schools (provide name/s): _____
Authorized to receive information regarding:
- ☐ Appointment absentee information

I authorize Family Medicine of SayeBrook, to contact me by text message regarding appointment and prescription refill information. *I understand that SMS messages may be subject to carrier fees and are patient responsibility.*

☐ Yes ☐ No

I authorize Family Medicine of SayeBrook to access my prescription history and for that information to be entered into my medical record.

☐ Yes ☐ No

I give authorization for the release of Protected Health Information by voice, text message or email.

☐ Yes ☐ No

Email address: _____

Authorized to receive information regarding:

- ☐ Extended: Test results, including but not limited to: lab, x-rays, prescription information and financial information.
- ☐ Brief: Appointment information only

Rights of the Patient

For **email and/or text communication**, I understand that if information is *not* sent in an encrypted (secure) manner, there is a risk it could be access inappropriately. I still elect to receive email and/or text communication as selected.

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 the document. I understand that a revocation is not effective in cases where the information has already bee disclosed but will be effective going forward.

I understand that information used or disclosed as a result of the authorization may be subject to re-disclosure 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.

_____ _____

Signature of Patient or Personal Representative Date

Description of Personal Representative's Authority: _____
Necessary documentation to be kept on file.

Family Medicine of SayeBrook

Date: _____

Name: _____ Date of Birth: _____

Local Pharmacy: _____

Address: _____

_____

Phone Number: _____

Mail Order Pharmacy: _____

Family Medicine of SayeBrook

Karen L. Mahood, DO
Edward R. McCarthy, DO
Jonathan D. Bornfreund, DO
Mercedes Davis, PA-C
Catherine Tumbleson, PA-C

106 Lansford Court, Ste. 100
Myrtle Beach, SC 29588
www.familymedicineofsayebrook.com

Phone 843-293-8850
Fax 843-293-8860

ACCT#: _____

AUTHORIZATION TO RELEASE INFORMATION

I,_____,_____
(name) (date of birth)
_____ hereby authorize release of my medical records from:
(social security number)

Physician or Medical Facility _____

Address _____
Phone_____Fax_____to the attention of:

__Edward R. McCarthy, DO __Jonathan D. Bornfreund, DO __Karen L. Mahood, DO

__Mercedes Davis, PA-C __Catherine Tumbleson, PA-C

Description of the information to be released: (check all that apply)
MOST RECENT

_____ Labs
_____ Discharge Summary
_____ Radiology (CT, MRI, X-Ray)
_____ Medical Records x **1 year**
_____ Immunization Record
_____ EKG
_____ Dexascan

Patient information is needed for:
_____ Continuing Medical Care
_____ Personal Use
_____ Other: _____

- I understand that the information in my medical records may include information relating to treatment of drug or alcohol abuse, mental health, genetic information, sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), AIDS related complex (ARC) and/or human immunodeficiency virus (HIV).
- I understand that I may inspect or copy the protected health information described by this authorization.
- I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal and state privacy regulations.
- I understand that I may revoke or terminate this authorization by submitting a written revocation to Family Medicine of SayeBrook, LLC.
- I understand my records are protected under federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. Federal regulations also prohibit any further re-disclosure of this information by the recipient with which you have consented. I hereby release FMS and any associated staff from all liability or legal responsibilities that may arise from the release of such records.

Patient (or patient representative)Signature:_____Date: _____
This authorization shall be in effect for one year from date signed.

Relationship of patient representative to patient: _____

Witness Signature: _____

Family Medicine at SayeBrook

Patient Name: _____
Account #: _____
Date: _____

Personal Health History

Past Medical History

- ☐ High Blood Pressure
- ☐ Thyroid Disease
- ☐ High Cholesterol
- ☐ Hospitalization Why? _____
- ☐ Other Illness List: _____

- ☐ Diabetes
- ☐ Anemia
- ☐ Asthma

- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Depression

Number of pregnancies _____ Number of Children _____ Date of Last Menses _____

Past Surgery

- ☐ Appendix
- ☐ Tonsils
- ☐ C-Section
- ☐ Gallbladder
- ☐ Hysterectomy

- ☐ Other Surgeries

_____
_____
_____
_____

Current Medications

Medication Name	Dose	When Taken	Refills Needed
			☐ Y ☐ N
			☐ Y ☐ N
			☐ Y ☐ N
			☐ Y ☐ N
			☐ Y ☐ N

☐ Allergies? (If yes, please explain) _____
_____

Family History

- ☐ Heart Disease
- ☐ Stroke

- ☐ High Blood Pressure
- ☐ Cancer

- ☐ Diabetes
- ☐ Depression

Work History

Current Occupation: _____
History of exposure to chemicals, fumes or asbestos: _____
Any job related injury? ☐ Yes ☐ No
Are you disabled? ☐ Yes ☐ No Why? _____

Social History

Smoke ☐ Yes ☐ No How much? _____packs per day Started _____years ago Quit _____
Alcohol ☐ Yes ☐ No How many drinks? _____per day or week (circle one) Illegal Drugs ☐ Yes ☐ No
History of Sexually Transmitted Diseases ☐ Yes ☐ No
Do you think you have any risk of AIDS? ☐ Yes ☐ No

Family Medicine at SayeBrook

Patient Name:_____
Account #:_____
Date:_____

Review of Systems

General Questions:
- ☐ Change in appetite
- ☐ Fatigue
- ☐ Headache
- ☐ Weight Gain
- ☐ Weight Loss

Allergy Immunology:
- ☐ Seasonal Allergies
- ☐ Sneezing

Ophthalmologic (Eye):
- ☐ Blurred Vision
- ☐ Eye Problems

Ent:
- ☐ Difficulty Swallowing
- ☐ Ear Problems
- ☐ Nose/Throat Problems
- ☐ Snoring
- ☐ Swollen Glands

Endocrine:
- ☐ Excessive Sweating
- ☐ Excessive Thirst
- ☐ Thyroid Problems

Respiratory:
- ☐ Breathing Problems
- ☐ Cough
- ☐ Shortness of Breath
- ☐ Wheezing

Breast:
- ☐ Breast Lump
- ☐ Breast Pain

Cardiovascular:
- ☐ Chest Pain
- ☐ Edema
- ☐ Irregular Heart Beat
- ☐ Palpitations

Gastrointestinal:
- ☐ Abdominal Pain
- ☐ Blood in Stool
- ☐ Constipation
- ☐ Diarrhea

Women Only:
- ☐ Irregular Menses
- ☐ Painful Menses
- ☐ Vaginal Discharge/Itching

Men Only:
- ☐ Difficulty Initiating Stream
- ☐ Lump in Groin
- ☐ Penile Discharge
- ☐ Scrotal Pain
- ☐ Scrotal Swelling

Genitourinary:
- ☐ Blood in Urine
- ☐ Frequent Urination
- ☐ Painful Urination

Musculoskeletal:
- ☐ Back Problems
- ☐ Muscle Aches
- ☐ Painful Joints
- ☐ Weakness

Skin:
- ☐ Discoloration
- ☐ Skin Lesions

Neurologic:
- ☐ Balance Difficulty
- ☐ Dizziness
- ☐ Memory Loss
- ☐ Tremor

Psychiatric:
- ☐ Anxiety
- ☐ Depressed Mood
- ☐ Difficulty Sleeping
- ☐ Suicidal Thoughts

Family Medicine of SayeBrook

Patient Name:_____
Account #:_____
Date:_____

Preventive Health Medicine

Please take a few moments to fill in the dates you last received these services.

Service	Month & Year
Colonoscopy – Colon Cancer Screening	
Eye Exam	
Complete Physical	
Hepatitis B Shot/Vaccine	
TB Skin Test – Tuberculosis Screening	
Lipid Profile/Cholesterol Check	
Tetanus Shot/Vaccine	
Pneumonia Shot/Vaccine	
Pap (Women)	
Dexascan – Bone Density (Women)	
Mammogram (Women)	
PSA – Prostate Screening (Men)	
Hemoglobin A1C (Diabetic)	
Urine Protein Test (Diabetic)	
Foot Exam (Diabetic)	
EKG	

Family Medicine of SayeBrook

Patient Name: _____

Account #: _____

Health & Beauty Questionnaire

Please select which of the following services that is of interest to you.

- ☐ Botox Cosmetic
- ☐ Juvederm Dermal Filler
- ☐ Latisse for Longer, Thicker Lashes
- ☐ Acne Treatment
- ☐ Skin-Care Advise
- ☐ Obagi Medical Skin Care Products
- ☐ Liver Spot/Age Spot Correction
- ☐ Skin Cancer Evaluation
- ☐ Mole Evaluation and Removal
- ☐ Weight Management
- ☐ Other, please specify: _____

If you would like to be added to our cosmetic email distribution list, providing information regarding new products and specials, please add your e-mail address below:

Name:_____ Account #: _____

Email:_____Date: _____

Family Medicine of SayeBrook

Patient Name: _____

Account #: _____

Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name & Address: _____

_____

_____

I have received a copy of the Notice of Privacy Practices for the above named practice.

_____ _____

Signature Date

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

An emergency existed & a signature was not possible at the time.
The individual refused to sign.
A copy was mailed with a request for a signature by return mail.
Unable to communicate with the patient for the following reason: _____

_____

_____

Other: _____

_____

_____

_____

Prepared By _____

Signature _____

Date _____ Chart _____

Family Medicine of SayeBrook Consent for Telehealth Services

1) Consent for Treatment: I consent to telehealth care performed by my provider and all associated healthcare workers at Family Medicine of SayeBrook. This includes examinations, treatment, and other health care services deemed medically necessary by the provider. I acknowledge that no guarantees have been made to me as to the result of any exam or treatment. I understand that I have the option to refuse the delivery of telehealth services at any time without affecting my right to future care or treatment.

2) Consent for Telehealth Services: Telehealth involves transmissions of video and includes the exchange of protected health information pertinent to my care that includes but is not limited to test results, patient history, social history, medication management and other data deemed necessary for treatment.

    a. *All confidentiality protections required by law or regulation will apply to my care.*
    b. *I have the right to refuse or stop participation in telehealth services at any time and request an in-person appointment. I understand that in-person services might not be available on the same day.*

3) Records and Release of Information: The details of the Telehealth visits will become part of my medical records. Data will not be transmitted to people outside except as described below, and/or if I provide written consent.
    a. I will have access to all the information in my medical record resulting from the telehealth services that I receive, as provided by federal and state law.
    b. The Providers may use or disclose my health information for treatment, continuity of care, payment, or internal operations or when required by law or regulation in certain unique situations.
    c. All releases of information are subject to the same laws and regulations as in person care.

4) Payment Agreement/Assignment of Benefits: I agree to be responsible for any co-payments, deductibles, or other charges from the Providers and their providers that are not covered or paid by insurance except as prohibited by any state or federal law. I authorize Family Medicine of SayeBrook to file claim for payment and assign any benefits to Family Medicine of SayeBrook. It is my responsibility to know what providers and telehealth services are covered under my insurance plan. I understand that I may be billed for and agree to pay for my portion of telehealth services billed by Family Medicine of SayeBrook.

By signing this form, I acknowledge that I have read this information and agree to treatment by telehealth.

Printed Name: _____ Date of Birth: _____

Patient or Guardian Signature: _____ Date: _____

Family Medicine of SayeBrook

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

If you have any questions about this Notice please contact the PrivacyOfficer. By
Mail: 106 Lansford Court, Ste 100 Myrtle Beach, SC 29588
By Phone: 843-293-8850

Effective Date: November 2006
Revised: July 15, 2013

We are committed to protect the privacy of your personal health information (PHI).

This Notice of Privacy Practices (Notice) describes how we may use within our practice ornetwork and disclose (share outside of our practice or network) your PHI to carry outtreatment, payment or health care operations. We may also share your information for other purposes that are permitted or required by law. This Notice also describes your rights to access and control your PHI.

We are required by law to maintain the privacy of your PHI. We will follow the terms outlined in this Notice.

We may change our Notice, at any time. Any changes will apply to all PHI. Upon your request, we will provide you with any revised Notice by:

- Posting the new Notice in our office.
- If requested, making copies of the new Notice available in our office or by mail.
- Posting the revised Notice on our website: (www.familymedicineofsayebrook.com).

Uses and Disclosures of Protected Health Information

We may use or disclose (share) your PHI to provide health care treatment for you.

Your PHI 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.

EXAMPLE: Your PHI may be provided to a physician to whom you have been referred for evaluation to ensure that the physician has the necessary information to diagnose or treat you. We may also share your PHI from time to time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

We may also share your PHI with people outside of our practice that may provide medical care for you such as home health agencies.

Notice of Privacy Practices

We may use and disclose your PHI to obtain payment for services. We may provide your PHI to others in order to bill or collect payment for services. There may be services for which we share information with your health plan to determine if the service will be paid for.

PHI may be shared with the following:

- Billing companies
- Insurance companies, health plans
- Government agencies in order to assist with qualification of benefits
- Collection agencies

EXAMPLE: You are seen at our practice for a procedure. We will need to provide a listing of services such as x-rays to your insurance company so that we can get paid for the procedure. We may at times contact your health care plan to receive approval PRIOR to performing certain procedures to ensure the services will be paid for. This will require sharing of your PHI.

We may use or disclose, as needed, your PHI in order to support the business activities of this practice which are called health care operations. EXAMPLES:

- Training students, other health care providers, or ancillary staff such as billing personnel to help them learn or improve their skills.
- Quality improvement processes which look at delivery of health care and for improvement in processes which will provide safer, more effective care for you.
- Use of information to assist in resolving problems or complaints within the practice.

We may use and disclosure your PHI in other situations without your permission:

- If required by law: The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. For example, we may be required to report gunshot wounds or suspected abuse or neglect.
- Public health activities: The disclosure will be made for the purpose of controlling disease, injury or disability and only to public health authorities permitted by law to collect or receive information. We may also notify individuals who may have been exposed to a disease or may be at risk of contracting or spreading a disease or condition.
- Health oversight agencies: 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.
- Legal proceedings: To assist in any legal proceeding or in response to a court order, in certain conditions in response to a subpoena, or other lawful process.
- Police or other law enforcement purposes: The release of PHI will meet all applicable legal requirements for release.

Notice of Privacy Practices

- Coroners, funeral directors: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law
- Medical research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.
- Special government purposes: Information may be shared for national security purposes, or if you are a member of the military, to the military under limited circumstances.
- Correctional institutions: Information may be shared if you are an inmate or under custody of law which is necessary for your health or the health and safety of other individuals.
- Workers' Compensation: Your protected health information may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally established programs.

Other uses and disclosures of your health information.

- Business Associates: Some services are provided through the use of contracted entities called "business associates". We will always release only the minimum amount of PHI necessary so that the business associate can perform the identified services. We require the business associate(s) to appropriately safeguard your information. Examples of business associates include billing companies or transcription services.
- Health Information Exchange: We may make your health information available electronically to other healthcare providers outside of our facility who are involved in your care.
- Fundraising activities: We may contact you in an effort to raise money. You may opt out of receiving such communications.
- Treatment alternatives: We may provide you notice of treatment options or other health related services that may improve your overall health.
- Appointment reminders: We may contact you as a reminder about upcoming appointments or treatment

We may use or disclose your PHI in the following situations UNLESS you object.

- We may share your information with friends or family members, or other persons directly identified by you at the level they are involved in your care or payment of services. If you are not present or able to agree/object, the healthcare provider using professional judgment will determine if it is in your best interest to share the information. For example, we may discuss post procedure instructions with the person who drove you to the facility unless you tell us specifically not to share the information.
- We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death.
- We may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts.

Notice of Privacy Practices

The following uses and disclosures of PHI require your written authorization:

- Marketing
- Disclosures of for any purposes which require the sale of your information
- Release of psychotherapy notes: Psychotherapy notes are notes by a mental health professional for the purpose of documenting a conversation during a private session. This session could be with an individual or with a group. These notes are kept separate from the rest of the medical record and do not include: medications and how they affect you, start and stop time of counseling sessions, types of treatments provided, results of tests, diagnosis, treatment plan, symptoms, prognosis.

All other uses and disclosures not recorded in this Notice will require a written authorization from you or your personal representative.

Written authorization simply explains how you want your information used and disclosed. Your written authorization may be revoked at any time, in writing. Except to the extent that your doctor or this practice has used or released information based on the direction provided in the authorization, no further use or disclosure will occur.

Your Privacy Rights

You have certain rights related to your protected health information. All requests to exercise your rights must be made in writing. [Describe how the patient may obtain the written request document and to whom the request should be directed, i.e. practice manager, privacy officer.]

You have the right to see and obtain a copy of your protected health information.

This means you may inspect and obtain a copy of protected health information about youthat is contained in a designated record set for as long as we maintain the protected health information. If requested we will provide you a copy of your records in an electronic format. There are some exceptions to records which may be copied and the request may be denied. We may charge you a reasonable cost based fee for a copy of the records.

You have the right to request a restriction of your protected health information.

You may request for this practice not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. We are not required to agree with these requests. If we agree to a restriction request we will honor the restriction request unless the information is needed to provide emergency treatment.

There is one exception: we must accept a restriction request to restrict disclosure of information to a health plan if you pay out of pocket in full for a service or product unless it is otherwise required by law.

Family Medicine of SayeBrook

Notice of Privacy Practices

You have the right to request for us to communicate in different ways or in different locations.

We will agree to reasonable requests. We may also request alternative address or other method of contact such as mailing information to a post office box. We will not ask for an explanation from you about the request.

You may have the right to request an amendment of your health information.

You may request an amendment of your health information if you feel that the information is not correct along with an explanation of the reason for the request. In certain cases, we may deny your request for an amendment at which time you will have an opportunity to disagree.

You have the right to a list of people or organizations who have received your health information from us.

This right applies to disclosures for purposes other than treatment, payment or healthcare operations. You have the right to obtain a listing of these disclosures that occurred after April 14, 2003. You may request them for the previous six years or a shorter timeframe. If you request more than one list within a 12 month period you may be charged a reasonable fee.

Additional Privacy Rights

- You have the right to obtain a paper copy of this notice from us, upon request. We will provide you a copy of this Notice the first day we treat you at our facility. In an emergency situation we will give you this Notice as soon as possible.
- You have a right to receive notification of any breach of your protected health information.

Complaints

If you think we have violated your rights or you have a complaint about our privacy practices you can contact the privacy officer at Family Medicine of Sayebrook, LLC by mail at 106 Lansford Court, Ste 100 Myrtle Beach, SC 29588 or by phone at 843-293-8850.

You may also complain to the United States Secretary of Health and Human Services if you believe your privacy rights have been violated by us.

If you file a complaint we will not retaliate against you for filing a complaint.

This notice was published and becomes effective on July 15, 2013

Notice of Privacy Practices

Family Medicine of SayeBrook

Patient Copy

Patient Responsibility

OFFICE HOURS – Monday – Thursday 8-5 (closed for lunch 12-1) Friday 8-12. Appointments preferred. Same day appointments should be available if you call before 10:00 a.m. on the day you wish to be seen. Our office will attempt to contact you about your appointment two days prior. *If you fail to notify us at least 12 hours prior to your scheduled office visit and do not keep your appointment, you will be billed a $20 no show fee.* Your insurance company will not pay this fee and you will be responsible.

FINANCIAL POLICY – Payment is expected at the time of your office visit. We accept VISA, MasterCard, Discover, American Express, Debit Card, & Cash. Personal checks may be accepted with valid South Carolina Drivers License upon approval from a check verification service. Keep in mind that your insurance policy is a contract between you and yourinsurance company. As a service to you, we will file your insurance. ** If your insurance is not one we participate withthen you will be responsible for payment in full at the time of service. If we later receive a check from your insurer, we will refund any overpayment to you. ** If your insurance company is one we participate with you may pay your estimated portion at the time of service. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment. If we later receive a check from your insurer, we will refund any overpayment to you. **If you are a eligible individual enrolled in the Qualified Medicare Beneficiary (QBM) Program, please notify the receptionist prior to your visit.**
**Not all insurance plans cover all services. In the event your insurance plan determines a service to be "not covered", youwill be responsible for the complete charge. Payment is due upon receipt of a statement from our office.
There will be a $30 fee for all returned checks. Balances over 90 days old may be subject to collections.

SEPARATE BILLING – Certain laboratory services are processed and billed by Laboratory Corporation of America (Lab Corp). Therefore, for all pathology/cytology tests and certain lab tests, you will receive a separate bill for specimens sent to the above referenced laboratory.

DISABILITY / FMLA / LEAVE OF ABSENCE FORMS – There will be a minimum $20 charge for form completion. This fee must be paid in advance. Our office requires seven to ten business days to complete the forms. Some cases may require an office visit with the doctor.

AFTER HOURS / WEEKEND CALLS – Should you need to speak to a clinical staff member after hours call our office at (843) 293-8850 and listen carefully to the recorded message. *If it is a life-threatening emergency, call 911.*

PRESCRIPTION REFILLS – If you need a refill on your prescription(s) please visit the patient portal or contact us directly. This includes mail orderpharmacy refills or transfers of prescriptions from one pharmacy to another. Please allow 24 hours to process.

RETURN CALLS – All patient calls will be responded to in a timely manner, but some may take 24 hours before you receive a response. If you call by 3:00 P.M., every attempt will be made to have an answer to your question before the end of the day. Please leave a phone number(s) where you can be reached during the day. Return calls are responded to in this manner so that our physicians are not interrupted during that day's scheduled patient visits.

HEALTH INFORMATION – Clinical summaries are available upon request in the patient portal or the office.

By my signature, I understand that I am directly responsible to this office for all charges, and that I must provide a valid picture ID, current insurance, and health history information. I also understand that all co-payments co-insurance, and payments for services notcovered by insurance are due the date service are rendered. I request that payment of authorized Medicare and other insurance benefits be made on my behalf to Family Medicine of SayeBrook, LLC for any administration and its agents any information needed to determine these benefits payable to related services. I authorize you to release to HCFA and any other carrier and its agent any information needed to file and process my claim.

*I authorize the physicians of Family Medicine of SayeBrook, LLC, his/her staff to perform and do hereby consent to such medical treatment as he/she feels necessary, including diagnostic procedures, medical exams, and treatment as he/she feels necessary. I acknowledge that no guarantees have been made to me as to the result of any procedure, treatment, or examination.
I have read and understand the practices policies and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time.*

Patient Signature_____ Date _____

Patient Name Printed_____ Witness _____

Family Medicine of SayeBrook

Focus on Wellness

What to Expect at a Preventive Exam

Routine visits are scheduled to promote wellness and disease prevention. A preventive visit typically involves a physical exam of an asymptomatic patient with no significant complaint to be evaluated. The exam may also include additional services such as vaccinations, screening laboratories, ordering of screening tests and risk factor reduction counseling.

What to Bring to a Preventive Exam

There are many different insurance plans with various benefits, so it is advisable to bring the summary of preventive benefits provided by the insurance carrier to the appointment.

**Not all insurance plans offer coverage for preventive services.*

What to Expect if Treatment is Needed

If an abnormality is encountered or a pre-existing problem is addressed in the process of performing a preventive medicine exam and it requires a significant work-up including the ordering of diagnostic tests, medication and/or further follow up care, then the physician may bill for an office visit (subject to applicable copay, coinsurance, and/or deductible) in addition to the annual wellness exam.

Before scheduling an appointment for well care, please contact your carrier regarding coverage and benefits. Unfortunately, there are many carriers that do not cover well visits or immunizations.