

NOTICE OF PRIVACY PRACTICES

Please read and sign

Patient Health Information

Under federal law, your patient health information is protected and confidential. Patient health information includes information about your symptoms, test results, diagnosis, treatment and related medical information. Your health information also includes payment, billing and insurance information.

How we use your patient health information.

We use health information about you for treatment, to obtain payment for administrative purposes, for evaluation of the quality of care, and so forth. Under some circumstances we may be required to use or disclose information even without your consent.

Treatment: We will use and disclose your health information to provide you with medical treatment and services. We may also disclose the information to other health care providers who are participating in your treatment, to pharmacists who are filling your prescriptions, to laboratories performing tests and to family members who are helping with your care.

Payment: We will use and disclose your health information for payment purposes. For example, we may need to obtain authorization from your insurance company before providing certain types of treatment. We will submit bills and maintain records of payment from your health plan.

Operation: We may ask you to complete a sign-in sheet or staff members may ask you the reason for your visit so we can better care for you. Despite safeguards, it is always possible in a doctor's office that you may learn information regarding other patients or they may inadvertently learn something about you. In all cases, we expect our patients to maintain strict confidentiality.

We may use and disclose your health information to perform various routine functions, (e.g. quality evaluations or records analysis.)

We may use your information to contact you. We may also contact you to provide information about referrals for follow-up with lab results to inquire about your health or other reasons.

Special Situations: We may be required by law to report gunshot wounds, suspected abuse or neglect and so on. We may be required to disclose vital statistics, diseases and other similar information to public health authorities; we may be required to disclose information for audits and similar activities, in response to a subpoena or court order, or as required by law enforcement officials.

We may release information about you for worker's compensation or similar programs to protect your health or the health of others or for legitimate government needs, for approved medical research, or to certain entities in the case of death.

In some situations, we may ask for your written authorization before using or disclosing any identifiable health information about you. If you sign an authorization, you can later revoke authorization.

Individual Rights: you have certain rights with regard to your health information, for example: You may request restrictions on certain uses and disclosures of your health information, though we are not required to agree to such restrictions. You may ask to communicate with us confidentially, for example, sending notices to a special address.

In most cases, you have the right to get a copy of your health information. There may be a charge for the copies.

If you believe information in your record is incorrect, or if important information is missing, you have the right to request that we amend the existing information. You may request list of instances where we have disclosed health information about you for reasons other than treatment, payment or operation. There may be a charge for this information.

Our Legal Duty: We are required by law to protect and maintain the privacy of your health information, to provide this Notice about our legal duties and privacy practices, regarding health information and to abide by the terms of the Notice currently in effect. We may update or change our privacy practices and policies at any time. Before we make a significant change in our policies, we will change our Notice and post the new Notice in the patient reception areas. You may also request a copy of our Notice at any time.

If you are concerned about your privacy rights, or if you disagree with a decision we made about your records, you may contact the person listed below. You also may send a written complaint to the U.S. Department of Health and Human Services. You will not be penalized in any way for filing a complaint.

Contact Person: If you have any questions, requests, or complaints, please contact:

WELLNESS FAMILY MEDICINE
Attn: Jayne Martin Practice Manager
1241 Boiling Springs Rd.
Spartanburg, SC 29303
(864) 591-0992
jmartin@wellnessfamilymedicine.com

HIPPA South Carolina
US DHHS
Atlanta Federal Center
Suite 3870
61 Forsyth Street
Atlanta, GA 30303-8909

____ I understand that a patient's health information is private and confidential. I understand that Wellness Family Medicine has procedures to protect a patient's privacy and preserve the confidentiality of every patient's personal health information. I will assist Wellness Family Medicine by following these procedures if I choose to exercise any of my rights described in the "Notice of Privacy Practices."

____ This patient acknowledgement will become part of my permanent record. I further acknowledge that should I become aware of another patient's private health matters, I will not disclose them to others and will treat any such knowledge as strictly confidential and private.

____ My signature verifies that I understand how Wellness Family Medicine may use patient information and I have read the "Notice of Privacy Practices" and I agree to be seen and treated under stipulations as described.

Patient's Names

Date of Birth

Today's Date

WELLNESS FAMILY MEDICINE

Request for authorization for disclosure of Protected Health Information to family member(s), friend(s) or caregiver(s)

Name

Relationship

Patient Signature: _____

Patient DOB: _____

Mother's Maiden Name: _____

If the person(s) authorized above call for access to your HPI, they will have to give the above identifiers in order to have access to the information over the phone. This includes billing information. Picture ID will be requested if requesting access in person.

Name _____ SS# _____ Date _____
Address _____ Occupation _____
Phone (home) _____ (work) _____ Date of birth _____ Age _____
Chief complaint _____

DRUG ALLERGENS

FAMILY HISTORY

	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy/Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

CURRENT MEDS

HOSPITALIZATION OR SURGERY

Reason	Date	Reason	Date

MEDICAL HISTORY

- | | | |
|--|---|--|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Lactose intolerance | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Gallbladder disease | <input type="checkbox"/> Chlamydia |
| <input type="checkbox"/> Heart palpitations | <input type="checkbox"/> Prostate disease | <input type="checkbox"/> Scarlet fever |
| <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Bowel irregularity | <input type="checkbox"/> Chronic rashes |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Incontinence | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Dizziness/Fainting | <input type="checkbox"/> Sexual/menstrual dysfunction | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Peripheral vascular disease | <input type="checkbox"/> Venereal disease | <input type="checkbox"/> Measles |
| <input type="checkbox"/> Allergies/Hay fever | <input type="checkbox"/> Frequent infections | <input type="checkbox"/> Rubella |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Anemia | <input type="checkbox"/> Diphtheria |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Tetanus |
| <input type="checkbox"/> Ulcer | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Other |
| <input type="checkbox"/> GI disorder | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Other |

WOMEN ONLY: Pregnant? Yes No Planning pregnancy? Yes No

MEN ONLY: It's common for men to occasionally experience erection difficulties. Is this something that happens to you? Yes No
How often does this occur? Frequently Sometimes Rarely

HABITS

- | | | |
|---|---|---|
| <input type="checkbox"/> Smoke: Packs daily _____
How long? _____
Interested in stopping? _____ | <input type="checkbox"/> Coffee: Cups daily _____
Other caffeine _____ | <input type="checkbox"/> Sleep: Difficulty falling asleep _____
Continuity disturbances _____
Snoring _____
Early morning awakening _____
Daytime drowsiness _____
Other _____ |
| <input type="checkbox"/> Exercise routine: _____ | <input type="checkbox"/> Alcohol: Type _____
Amount _____
Salt intake _____
Fat intake _____ | |

None

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AUTHORIZATION TO RELEASE INFORMATION

I authorize release of my medical record information, pursuant to applicable federal and state laws, rules and regulations, to third party payers and other providers participating in my care, that agree to treat my information in a confidential manner in accordance with all applicable federal, state, and local laws. I further authorize any other individual or entity that has provided health care to me to release to Wellness Family Medicine, any and all of my medical record information, whether in printed or electronic form, needed to provide me with informed care. I may revoke my consent for the release of this information at any time; except to the extent that action has been taken in reliance on the consent.

ASSIGNMENT OF BENEFITS

I hereby request that payment of authorized Medicare, Medicaid and all other insurance benefits be made on my behalf to Wellness Family Medicine for any services provided to me and/or my dependents. I authorize any holder of medical information about me and/or my dependents to release to the appropriate entity and its agents any information needed to determine these benefits payable for related services.

GUARANTEE OF PAYMENT

I agree to pay all applicable charges, which are not paid in full by my insurance. If amounts due to deductible, co-payment, co-insurance are not paid according to this financial policy, the account shall be deemed delinquent. In the event that I default on payment of my account, I understand I am responsible for any and all cost incurred on the collection of my account, including court cost and reasonable attorney's fee. If the debt is assigned to a third party collection agency, I agree to be responsible for collection fees and interest due to amounts in default.

WRITTEN ACKNOWLEDGEMENT OF PRIVACY PRACTICES

I hereby acknowledge that I have received and had an opportunity to ask questions concerning the Notice of Privacy Practice of Wellness Family Medicine

 Patient's Signature

 Date

 Responsible Party

 Relationship to patient

Wellness Family Medicine FINANCIAL POLICY

Your Plan	What You Do	What We Do
Medicare	Pay your deductible (\$147 for 2013) and co-insurance (20% of the allowable)	We will file Medicare for you.
Medicare and a secondary insurance	No payment due at time of service.	We will file Medicare and your secondary insurance for you.
Medicare and Medicaid	No payment due at time of service.	We will file Medicare and Medicaid for you.
Medicaid	\$3.30 co-pay at every visit	We will check your Medicaid eligibility before every visit and will file Medicaid for you.
Medicaid HMO	Your card must have the name of our provider to be seen. No payment due at time of service.	We will check your Medicaid eligibility before every visit and will file Medicaid for you.
Blue Cross Blue Shield	Pay your deductible, co-insurance or co-pay at time of service.	We will check your eligibility before every visit and will file your Blue Cross insurance for you.
Insurance we are not contracted with	Pay the visit in full at time of service.	We will file your insurance for you and assign benefits to you so you will receive payment from your insurance plan.
Worker's Compensation	You must have opened a claim with your employer to be seen. No payment due at time of service.	We will file your Worker's Compensation Insurance for you.
Automobile Accident	You must have opened a claim with your insurance company to be seen. If your insurance will not pay in full, you will pay the balance at time of service.	We will call to find out the terms of and will file your automobile insurance for you. We do not file medical insurance if we know your automobile insurance is responsible.
Self-pay	Pay for the visit in full at time of service. We offer a 30% discount for cash at time of service.	None.

Other fees:

- Returned check fee - \$30.00
- No-show fee - \$25.00
- Form completion fee - \$15.00 each form

PLEASE SIGN THE BACK OF THIS FORM

AGREEMENT TO PAYMENT POLICY

I acknowledge that I received a copy of Wellness Family Medicine's financial policy and agree to the terms of payment due.