SC INTERNAL MEDICINE ASSOCIATES AND REHABILITATION, L.L.C.
Established 1985

1 WELLNESS BOULEVARD, ₹ 200
IRMO, SOUTH CAROLINA 29063
PHONE: (803) 749-1111
FAX: (803) 749-0050

PATIENT INFORMATION
(PLEASE PRINT)

☐ Mr. ☐ Ms. ☐ Dr. ☐ Mrs. ☐ Miss Patient's Last Name: First: Middle Initial:

Marital status: ☐ Single ☐ Mar ☐ Div ☐ Sep ☐ Wid Nickname: Birth/Maiden Name:

Birth Date: Gender: ☐ M ☐ F SSN: Email Address:

Preferred Language: Race: Ethnicity: Driver's License Number: State: Exp. Date:

Home phone: Work phone: Cell phone:

Address: City: State: ZIP Code:

Occupation: Employer & Address: Employer phone:

Referred to practice by: ☐ Dr. _____ ☐ Patient _____ ☐ Other _____

May we include your name on the thank you letter we send to the person who referred you to our practice? ☐ Yes ☐ No

INSURANCE INFORMATION
(PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

Person responsible for bill: (if self, please skip to Primary Insurance) Is this person a patient at our practice? ☐ Yes ☐ No

Date of Birth: Address: Home Phone:

Occupation: Employer & Address: Employer phone:

****Policy Holder's Name, SSN, Date of Birth and Relationship to Patient are REQUIRED to file all insurance claims.****

Primary Health Insurance Company:

*Policy Holder's Name: (as it appears on insurance card) *SSN: *Birth date:

Group Number: Policy Number: Co-Payment: $

*Patient's relationship to Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Other

Secondary Health Insurance Company:

*Policy Holder's Name: (as it appears on insurance card) *SSN: *Birth date:

Group Number: Policy Number: Co-Payment: $

*Patient's relationship to Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Other

IN CASE OF EMERGENCY (LOCAL FRIEND/ RELATIVE)

Name: Relationship: Phone #: Alt. Phone #:

Name: (not living at same address) Relationship: Phone #: Alt. Phone #:

The above information is true to the best of my knowledge. I authorize South Carolina Internal Medicine Associates & Rehabilitation, LLC (SCIM) or insurance company to release any information required to process my claims. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I understand payment is due at time of service, and that SCIM reserves the right to dismiss patients that fail to keep their accounts current after reasonable attempts to collect payments have been made. I further agree to pay all reasonable costs and late fees should my account be turned over to collections.

Patient/Guardian Signature: _____ Date: _____

SC Internal Medicine Associates and Rehabilitation, LLC

Patient Authorization for Disclosure of Protected Health Information (PHI) to an Individual

This form allows you to indicate which individuals you authorize to have access to your protected health information, for reasons other than treatment, payment and healthcare operations (reasons already allowed by law). Please review it carefully.

Please print all information. Form must be signed and dated each year, see page 2.

Patient Name: _____

Social Security Number: _____ Date of Birth: _____

I authorize the practice listed below to disclose or share my protected health information (PHI):

Practice Name: **SC Internal Medicine Associates and Rehabilitation, LLC**

Provider: _____

Address: **One Wellness Blvd., Suite 200**

City: **Irmo** State: **SC** Zip: **29063**

Phone: **803-749-1111** Fax: **803-749-0050**

I authorize the practice to disclose or provide protected health information about me to the individual(s) listed below (list each family member, friend, or other individual to receive PHI):

Name: _____

Phone: _____ Relationship: _____

Name: _____

Phone: _____ Relationship: _____

Name: _____

Phone: _____ Relationship: _____

Purpose of disclosure (please record the purpose of the disclosure or check patient request):

☐ Patient Request

☐ Other (please specify): _____

I authorize the practice to disclose the following protected health information about me to the entity, person, or persons identified above (check only those items of your record to be disclosed):

- ☐ Entire patient record
- ☐ Office notes ☐ Lab results ☐ X-rays, image results
- ☐ Hospital, nursing home, home health, hospice, and other physician records
- ☐ Record of HIV and communicable disease testing
- ☐ Record of mental health or substance abuse treatment
- ☐ Financial history report (previous 3 years only)
- ☐ Only send the following: _____

This authorization will expire at the end of the calendar year (December 31) of your last signature below, unless you specify an earlier termination. You must renew or submit a new authorization after the expiration date to continue the authorization. You have the right to terminate this authorization at any time. You must notify our privacy manager, in writing, if you decide to terminate the authorization prior to the normal expiration date.

(Please list date of expiration if earlier than end of calendar year): _____

As stated in our Notice of Privacy Practices, you have the right to revoke or terminate this authorization by submitting a written request to our Privacy Manager. You may revoke an authorization at any time, in writing, except to the extent that your Healthcare Provider or the practice has taken an action in reliance on the use or disclosure indicated in the authorization.

The practice places no condition to sign this authorization on the delivery of healthcare or treatment.

We have no control over the person(s) you have listed to receive your protected health information. Therefore, your protected health information disclosed under this authorization will no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of the practice.

Patient Signature Date

You have the right to receive a copy of signed authorizations upon request.

South Carolina Internal Medicine Associates

Notice of Privacy Practices

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

Protected health information (PHI), about you, is maintained as a written and/or electronic record of your contacts or visits for healthcare services with our practice. Specifically, PHI is information about you, including demographic information (i.e., name, address, phone, etc.), that may identify you and relates to your past, present or future physical or mental health condition and related healthcare services.

Our practice is required to follow specific rules on maintaining the confidentiality of your PHI, using your information, and disclosing or sharing this information with other healthcare professionals involved in your care and treatment. This Notice describes your rights to access and control your PHI. It also describes how we follow applicable rules and use and disclose your PHI to provide your treatment, obtain payment for services you receive, manage our healthcare operations and for other purposes that are permitted or required by law.

Your Rights Under The Privacy Rule

Following is a statement of your rights, under the Privacy Rule, in reference to your PHI. Please feel free to discuss any questions with our staff.

You have the right to receive, and we are required to provide you with, a copy of this Notice of Privacy Practices - We are required to follow the terms of this notice. We reserve the right to change the terms of our notice, at any time, and to make the new Notice provisions effective for all PHI that we maintain. We will provide you with a revised Notice if you call our office and request that a revised copy be sent to you in the mail or ask for one at the time of your next appointment. The Notice will also be posted in a conspicuous location in the practice, and if such is maintained, on the practice's web site.

You have the right to authorize other use and disclosure - This means you have the right to authorize any use or disclosure of PHI that is not described within this notice. For example, we would need your written authorization to use or disclose your PHI for marketing purposes, for most uses or disclosures of psychotherapy notes, or if we intended to sell your PHI. You may revoke an authorization, at any time, in writing, except to the extent that your healthcare provider, or our practice has taken an action in reliance on the use or disclosure indicated in the authorization.

You have the right to request an alternative means of confidential communication – This means you have the right to ask us to contact you about medical matters using an alternative method (i.e., email, fax, telephone), and/or to a destination (i.e., cell phone number, alternative address, etc.) designated by you. You must inform us in writing, using a form provided by our practice, how you wish to be contacted if other than the address/phone number that we have on file. We will follow all reasonable requests.

You have the right to inspect and obtain a copy your PHI - This means you may submit a written request to inspect, and obtain a copy of your complete health record. If your health record is maintained electronically, you will also have the right to request a copy in electronic format. We have the right to charge a reasonable, cost-based fee for paper or electronic copies as established by federal guidelines. In most cases, we will provide requested copies within 30 days.

You have the right to request a restriction of your PHI - This means you may ask us, in writing, not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. If we agree to the requested restriction, we will abide by it, except in emergency circumstances when the information is needed for your treatment. In certain cases, we may deny your request for a restriction. You will have the right to request, in writing, that we restrict communication to your health plan regarding a specific treatment or service that you, or someone on your behalf, has paid for in full, out-of-pocket. We are not permitted to deny this specific type of requested restriction.

You have the right to request an amendment to your protected health information - This means you may submit a written request to amend your PHI for as long as we maintain this information. In certain cases, we may deny your request.

You have the right to request a disclosure accountability - You may request a listing of disclosures we have made of your PHI to entities or persons outside of our practice except for those made upon your request, or for purposes of treatment, payment or healthcare operations. We will not charge a fee for the first accounting provided in a 12-month period.

You have the right to receive a privacy breach notice - You have the right to receive written notification if the practice discovers a breach of your unsecured PHI, and determines through a risk assessment that notification is required.

If you have questions regarding your privacy rights or would like to submit a written request, please feel free to contact our Privacy Manager. Contact information is provided at right under Privacy Complaints.

How We May Use or Disclose Protected Health Information

Following are examples of uses and disclosures of your protected health information that we are permitted to make. These examples are not meant to be exhaustive, but to describe possible types of uses and disclosures.

Treatment - We may use and disclose your PHI to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party that is involved in your care and treatment. For example, we would disclose your PHI, as necessary, to a pharmacy that would fill your prescriptions. We will also disclose PHI to other Healthcare Providers who may be involved in your care and treatment.

Payment - Your PHI will be used, as needed, to obtain payment for your healthcare services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the healthcare services we recommend for you such as, making a determination of eligibility or coverage for insurance benefits.

Healthcare Operations - We may use or disclose, as needed, your PHI in order to support the business activities of our practice. This includes, but is not limited to business planning and development, quality assessment and improvement, medical review, legal services, auditing functions and patient safety activities.

Special Notices - We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment. We may contact you by phone or other means to provide results from exams or tests, to provide information that describes or recommends treatment alternatives regarding your care, or to provide information about health-related benefits and services offered by our office.

We may contact you regarding fundraising activities, but you will have the right to opt out of receiving further fundraising communications. Each fundraising notice will include instructions for opting out.

Health Information Organization - The practice may elect to use a health information organization, or other such organization to facilitate the electronic exchange of information for the purposes of treatment, payment, or healthcare operations.

To Others Involved in Your Healthcare - Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person that you identify, your PHI that directly relates to that person's involvement in your healthcare. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose PHI to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care, of your general condition or death. If you are not present or able to agree or object to the use or disclosure of PHI (e.g., in a disaster relief situation), then your healthcare provider may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the PHI that is necessary will be disclosed.

Other Permitted and Required Uses and Disclosures - We are also permitted to use or disclose your PHI without your written authorization, or providing you an opportunity to object, for the following purposes: if required by state or federal law; for public health activities and safety issues (e.g. a product recall); for health oversight activities; in cases of abuse, neglect, or domestic violence; to avert a serious threat to health or safety; for research purposes; in response to a court or administrative order, and subpoenas that meet certain requirements; to a coroner, medical examiner or funeral director; to respond to organ and tissue donation requests; to address worker's compensation, law enforcement and certain other government requests, and for specialized government functions (e.g., military, national security, etc); with respect to a group health plan, to disclose information to the health plan sponsor for plan administration; and if requested by the Department of Health and Human Services in order to investigate or determine our compliance with the requirements of the Privacy Rule.

Privacy Complaints

You have the right to complain to us, or directly to the Secretary of the Department of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying the Privacy Manager at:

803-749-1111

We will not retaliate against you for filing a complaint.

Effective Date January 1, 2018 Publication Date January 1, 2018

SC Internal Medicine Associates and Rehabilitation, LLC

Notice of Privacy Practices Acknowledgement Form

The Notice of Privacy Practices describes how medical information about you may be used and disclosed and how you can gain access to this information. Please review it carefully.

I acknowledge receiving SC Internal Medicine Associates and Rehabilitation, LLC's Form 7.20, Notice of Privacy Practices.

Patient Name _____ Date of Birth _____

Signature _____ Date _____

Prescriptions & Prior Authorizations

South Carolina Internal Medicine Associates and Rehabilitation, L.L.C. - OFFICE POLICIES

PRESCRIPTION REFILL POLICY

All prescription refill requests require an office visit with a healthcare provider**. Supply your provider with an **updated formulary list** from your insurance company and remember to bring all of your current prescription medication bottles (with attached pharmacy labels) to every appointment. Before leaving the office, be sure you will have enough medication to last until your next scheduled appointment. In the event you need a refill before then, you will need to make an appointment with a provider or take advantage of our walk-in service.

* Please note that our walk-in service is not available for controlled substance refills; you must schedule an appointment with the prescribing physician for all controlled substance refills.

PRIOR AUTHORIZATIONS FOR PRESCRIPTIONS POLICY

Prior Authorizations for prescription medications require an office visit with a healthcare provider. To avoid the confusion of dealing with prior authorizations and additional office visits, it is very important that you supply us with a copy of your formulary (a list of preferred medications your insurance plan will cover). Your insurance company will require prior authorization for any medication prescribed that is not listed on your formulary.

In the event a prior authorization is required, it is your responsibility to a) contact your insurance company to obtain an updated formulary and all appropriate paperwork, then b) schedule an appointment with one of our healthcare providers to fully understand all options available to you.

Due to the significant amount of time required to address prior authorization requests, an office visit is required; this assures that each patient receives the highest quality of medical care and allows you the opportunity to speak personally with a provider and ask questions.

SC INTERNAL MEDICINE ASSOCIATES AND REHABILITATION, L.L.C. Founded 1986

SC Internal Medicine Associates and Rehabilitation, LLC

Financial Policy

Thank you for choosing South Carolina Internal Medicine Associates and Rehabilitation, LLC (SCIM) for your medical needs. Our staff is committed to providing you with the best care possible. Your clear understanding of the Financial Policy, which is an agreement between the practice and the patient or guarantor, is important to our professional relationship. We require a signature to document that you have read and understand this policy.

INSURANCE/PAYMENT: Insurance plans vary considerably and we cannot predict or guarantee what part of our services will or will not be covered. On arrival, please sign in at the front desk and **present your current insurance card and photo identification as well as any other forms that may assist us in processing your claims correctly at every visit.** It is the responsibility of the patient to provide *accurate* and *timely* insurance information. Inaccurate or untimely information given to the staff that results in denial or non-coverage by your insurance company results in the guarantor being responsible for payment. If the patient is not the policy holder on the insurance, we require the policy holder's full name, date of birth, social security number and relationship to the patient to file all claims. If your plan requires, you must name SCIM as your primary care physician prior to your first appointment. If an SCIM physician is not named on your insurance as your primary care physician, your appointment will need to be rescheduled. According to your contractual agreement with your insurance plan, **you are responsible for your co-payment, coinsurance, and/or deductible at the time of service.** It is important for you to be an informed consumer who understands the specifications of your insurance policy regarding doctor visit coverage, referral/authorization requirements for specialty care, imaging studies, laboratory tests, emergency hospital care, etc. You should refer to information from your insurance company or call them if you have questions about your coverage.

BILLING: We accept cash, checks, MasterCard, Visa, American Express, and Discover. **Outstanding balances are due within 30 days unless prior arrangements have been made with the billing department.** For balances over 60 days, you will receive a final request for payment letter. Balances not paid in full within 10 days of the date on the final request letter will be forwarded to a collection agency. **You will be responsible for any costs incurred if your account is turned over to a collection agency,** which will include collection agency fees equaling **25%** of the outstanding balance, and in addition, court costs and attorney fees. ***We reserve the right to refuse service due to unpaid balances.***

The guarantor is responsible for full payment at the time of service. We realize that temporary financial problems may affect timely payment on your account. If such problems arise, we encourage you to contact our billing department promptly for payment arrangements and assistance in the management of your account.

Should your account balance become uncollectible due to bankruptcy, we will continue to see you on an emergency basis only for the next 30 days, giving you time to find a new source of medical care.

Please call if you have a question about your bill. Most problems can be settled quickly and easily and your call will prevent any misunderstandings.

Payment Policy on Outstanding Balances: SCIM offers alternative arrangements to assist you if you are not able to meet your financial obligation on outstanding balances. We offer a financial agreement that allows you to pay your past due balance over twelve (12) months. A signed agreement in addition to a 20% down payment is required on all outstanding balances. Credit/Debit card monthly draft are the preferred method of payment. In the event you are not able to set up a monthly draft, we will offer a

check agreement as long as the payments are made on time. If your agreement is unfulfilled we will be unable to schedule appointments.

IF WE PARTICIPATE WITH YOUR INSURANCE COMPANY: All services performed in our office will be submitted as a courtesy to your insurance. **All co-payments, deductibles, and coinsurance are due at the time of service.** All insurance carriers have a fee schedule from which they will reimburse. Not all services provided by this office are covered benefits in all contracts. Therefore, any balance not covered by insurance becomes the responsibility of the patient.

IF WE DO NOT PARTICIPATE WITH YOUR INSURANCE COMPANY: We are not able to bill your insurance and we cannot accept payment from them for the services performed. We will provide you with a bill so that you may submit the charges to your insurance company for reimbursement. **Payment for service is due in full at the time of service.**

IF YOU DO NOT HAVE INSURANCE: If you are not covered by insurance at the time of service, please be advised that **you will be responsible for all charges incurred at the time of service.**

NON-EMERGENCY APPOINTMENTS: We will reschedule non-emergency appointments if there is an overdue balance on your account with no financial agreement in place or if payment is not made at the time of service.

MISSED APPOINTMENTS/LATE CANCELLATIONS: Missed appointments represent a cost to us, to you, and to other patients who could have been seen in the time set aside for you. For cancellations, a 24 hour notice prior to the appointment is requested. However, we understand emergencies arise, so please call us if you must miss an appointment. **We reserve the right to charge a $25.00 fee for missed appointments without proper notification ($150.00 for missed physicals and $50.00 for new CMWL patient consults).**

RETURNED CHECKS: A **$35.00 fee** will be charged for all returned checks. If you write a check that is returned, your account will be placed on a cash only basis, meaning we will only accept cash or credit card payments.

AFTER-HOURS PHONE TRIAGE SERVICES: SCIM provides nursing triage phone services ("on-call coverage") after regular business hours. Effective November 1, 2012, we will charge **$25.00** if you choose to utilize our after-hours phone triage services. Please note that many insurance companies provide free nursing advice so you may want to call your insurance company first. If you use our services, we will expect you to pay for them and reserve the right to charge accordingly.

AFFIDAVITS/LEGAL MATTERS: Each Provider charges a fee for affidavits, letters, or forms that we prepare for legal or employment matters. Those fees are not billable to your insurance company or employer and are due at the time of service.

ANTI-VIDEO & AUDIO RECORDING POLICY: Video and audio recording is strictly prohibited in the office for all patient, family and physician interactions.

FORMS: We require at least 48 hours to complete all forms. An appointment may be required depending on the nature of the form and information requested.

MEDICAL RECORDS: If you request a copy of your medical records, you will be required to sign a medical record release form and pay a medical record fee prior to having your records copied (fee details stated on release form). Please allow up to 14 days for this request to be processed.

REFERRALS: If your insurance plan requires a written referral for you to see a specialist, for procedures, or laboratory tests, you must allow no less than 3 business days to complete the appropriate form(s) prior to obtaining services. You may have to reschedule your appointment if enough notice is not given to prepare your referral. Emergency referrals will be completed on the same day. Retroactive referrals cannot be written and will not be honored. In general, we will not agree to a referral for a problem we have not been consulted about first.

REFUNDS: If you have a credit on your account, we will gladly refund the amount within thirty (30) days of your request (and if cleared by the Billing Department). You must provide a correct mailing address for your refund to be sent.

DISMISSAL PROCESS: There are several reasons that a patient may be dismissed from our practice. A few reasons are as follows:

- Failure to keep scheduled appointments
- Being verbally or physically abusive to staff
- Abuse of prescription drugs and/or failure to adhere to SCIM's narcotic policy
- Failure to meet financial obligations

A certified letter will be sent to your last known address notifying you that you are being dismissed from our practice. If you have a medical emergency within thirty (30) days of the date of the letter, one of our providers will be available for advice. After the thirty (30) days, you will no longer be seen at our practice by any provider. A copy of your medical record may be forwarded to your new doctor after a formal request is made and applicable fees (if any) are paid.

You may review this Financial Policy at www.scinternalmedicine.com.

PLEASE DO NOT SIGN THIS FORM UNLESS YOU HAVE READ IT.

Patient Acknowledgement: *I, _____ (print name), have read, understand, and agree to the SC Internal Medicine Financial Policy. I agree to pay at the time of service. I also understand that South Carolina Internal Medicine Associates and Rehabilitation, LLC reserves the right to dismiss patients that fail to keep their accounts current after reasonable attempts to collect payments have been made. I further agree to pay all reasonable costs and late fees should my account be turned over to collections. I also understand the terms of this Financial Policy may be amended by the practice without prior notification to the patient or guarantor.*

_____

Patient's or Responsible Party's Signature Date

_____

Witness Signature Date