



1773 VILLAGE PARK DRIVE ORANGEBURG, SC 29118 500 BASS DRIVE SANTEE, SC 29142

# PATIENT REGISTRATION

PATIENT NAME (LAST FIR	ST MIDDLE INITIAL)	PLEASE PRIN	ADDRESS	ETE ACL	VI KIES			
CITY, STATE		ZIF	P	HOME PH	ONE		CEL	L PHONE
PATIENT DATE OF BIRTH	PATIENT SSN			emale		MARITAL STA		Other
PATIENT EMPLOYER NAME		IENT EMPLOYER AD				ATE - ZIP)		EMPLOYER PHONE
	ONSIBLE PARTY INFOR		RELATION			□spouse	□paren	t □guardian
NAME (FIRST LAST MID	,		SS (if different	from patient				
HOME PHONE	WORK PHONE	SSN			BIRTH	DATE	EMPLOY	ER
INSURANCE INFORMATION	V							
PRIMARY INSURANCE NAMI		ADDRESS (STREE	T - CITY - ST.	ATE - ZIP)			PHONE	
GROUP NUMBER	ID NUMBER	EMPLOY	/ER				EMPLOYE	R PHONE
SECONDARY INSURANCE N	L AME	ADDRESS (STREE	T - CITY - ST.	ATE - ZIP)			PHONE	
GROUP NUMBER	ID NUMBER	EMPLOY	/ER				EMPLOYE	R PHONE
PRIMARY DOCTOR/FAMILY	DOCTOR ·			REFFERING	DOCTO	₹	. ""	·
IN CASE OF EMERGENCY CO	DNTACT			RELATIONS	БНІР		PHONE	E NUMBER
that are not covered o or charges not covered	s a courtesy, the practice of a covered charges not by insurance. I und	ot paid in full includerstand there is <b>BENEFITS:</b> I h	luding, but notes a fee for retinents	ot limited urned che ize my ins	to any cks (\$3 surance	co- payment 0.00) benefits be	, co- ins	agree to pay for services urance and/or deductible, ectly to the physician and on required in the
processing of this claim fees.	n and all future clain	ns. If my accour	nt is sent to a	collection	agenc	y, I agree to	pay all	collection and attorney
XVIII of the social Sec Security Administration information needed for	urity Act is correct. In or its intermediarient rithis or any Medicar	authorize the hos or carriers, or a carriers.	older of medi any additiona	cal or oth	er infor	mation abou	t me to	g for payment under Title be released to the Social of benefits, any
SIGNATURE (Patient or, i	if minor Signature of pa	arent or guardian)		DATE				
								<u> </u>

□Verified Patient Information Staff Initials:

DATES OF SERVICE FROM: TO:   AUTHORIZATION EXPIRES (UNLESS OTHERWISE NOTED THIS AUTHORIZATION WILL REMAIN FROM: TO:   IN SPFECT ONE YEAR FROM THE DATE SIGNED)   DATE:   AUTHORIZATION FROM THE DATE SIGNED)   DATE:   Records   Chart Notes   Radiology Reports   Operative Reports   History & Physicals				
DATES OF SERVICE FROM:  TO:  NEFFECT ONE YEAR FROM THE DATE STONED DATE  AUTHORIZATION Loginess Chinesynes NOTED THIS AUTHORIZATION WILL REMAIN IN SEFECT ONE YEAR FROM THE DATE STONED DATE  ALI Records  Charles  Release the following Information:  All Records  Charles  Release the following Information:  All Records  Charles  Release the following Information to the Notes  Release of the third party may not be required to ebide by this Authorization or applicable federal and state laws governing the use and disclosure of my health information. In writing a capt wine to inspect and/or obtain a copy of my health information maintained at this facility as provided in the party may note the required for the year or I provide a written notice of revocation to the Medical Record Department.  SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE.  DATE  If signed by LEGAL REPRESENTATIVE, RELATIONSHIP TO PATIENT  If authorize Singleton Health Center to disclose my health care information and jove these individuals the ability to pick up prescriptions and/or medications on my behalf. A photo 10 is required for prescription pickup. These individuals will be considered my emergency contacts.  Without authorization, no information may be shared. I authorize Singleton Health Center to disclose my personal health information to the following people:  Name:  Relationship:  Phone:  Relationship:  Relationship	Authorization to release health information to Name(s)			
Release the following information:    Call Records   Cart Notes   Redivides   Reports   Reports   Reports   Research	CITY, STATE	ZIP	HOME PHONE	DAYTIME PHONE
RELEASE OF INFORMATION  I understand that:  once "this facility" discloses my health information by my request, it cannot guarantee that Recipient will not re-disclose my health information to a titted party. The third party may not be required to abide by this Authorization or applicable federal and state laws governing the use and disclosure of my health information.  I may make a request in writing at any time to inspect and/or obtain a copy of my health information maintained at this facility as provided in the Federal Privacy Rule 45 CFR (164-524).  I may rends are protected and cannot be disclosed without written permission  in this Authorization will romain in affect for one year or I provide a written notice of revocation to the Medical Record Department.  SIGNATURE OF WITNESS (Optional):  EMAIL.  DISTRICT OR LEGAL REPRESENTATIVE, RELATIONSHIP TO PATIENT  SIGNATURE OF WITNESS (Optional):  Disclosure to Family or Loved Ones: Emergency Contracts  I authorize Singleton Health Center to disclose my health care information and give these individuals the ability to pick up prescriptions and/or medications on my behalf. A photo ID is required for prescription pickup. These individuals will be considered my emergency contacts. Without authorization, no information may be shared. I authorize Singleton Health Center to disclose my personal health information to the following people:  Name:  Relationship:  Phone:  Relationship:  Patient Initials  AUTHORIZATION FOR E-PRESCRIBE  I hereby grant authorization and consent for medical treatment and/or procedures for myself or the patient for whom I am the parent or legally authorized representative for which I am signing for, and understand that no guarantee or assurance has been made as to the results for which in any be obtained. I agree to allow my provider to access all of my medication history including medications prescription h	DATES OF SERVICE FROM: TO:	IN EFFECT ONE		THIS AUTHORIZATION WILL REMAIN
I understand that:  - once "Ibls Easility" disclases my health information by my request, it cannot guarantee that Recipient will not re-disclose my health information to a bird parly. The third parly may not be required to abide by this Authorization or applicable federal and state laws governing the use and disclosure of my health information.  - I may make a request in writing at any time to Inspect and/or obtain a copy of my health information maintained at this fedility as provided in the Federal Privacy Rule 45 CFR (164-524).  - In my records are protected and carnot be disclosed without written permission or bits Authorization will remain in effect for one year or I provide a written notice of revocation to the Medical Record Department.  SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE.  IF SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE, RELATIONSHIP TO PATIENT  SIGNATURE OF WITNESS (Optional):  Disclosure to Family or Loved Onesi Emergency Contacts  I authorize Singleton Health Center to disclose my health care information and to discuss my health care needs to those that I designate. I further authorize the release of my billing information and give these individuals this be ability to pick up prescriptions and/or medications on my behalf. A ploto ID is required for prescription pickup. These individuals will be considered my mergency contacts. Without authorization, no information may be shared. I authorize Singleton Health Center to disclose my personal health information to the following people:  Name:  Relationship:  Phone: ()  Name:  Relationship:  Phone: ()  Phone: ()  Phone: ()  Phone: ()  Patient initials  AUTHORIZATION FOR E-PRESCRIBE  I hereby grant authorization to electronically submit prescriptions on my behalf. I also grant permission to access my prescription history from outside sources.  Patient initials	Release the following information:  All Records  Chart Notes	Radiology Repor	rts	☐ History & Physicals
once 'this facility' discloses my health information by my request, it cannot guarantee that Recipient will not readisone my health information to a third party may not be required to abide by this authorization or applicable federal and state laws governing the use and disclosure of my health information.  I may make a request in writing at any time to inspect and/or obtain a copy of my health information maintained at this facility as provided in the Federal Privacy Rule 45 CFR (164.524).  I may records are protected and cannot be disclosed without written permission  I may records are protected and cannot be disclosed without written permission  I may record are protected and cannot be disclosed without written permission  I may record the maintain in effect for one year or I provide a written notice of revocation to the Medical Record Department.  SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE  IF SIGNED BY LEGAL REPRESENTATIVE, RELATIONSHIP TO PATIENT  I authorize Singleton Health Center to disclose my health care information and to discuss my health care needs to those that I designate. I further authorize the release of my billing information and give these individuals the ability to pick up prescriptions and/or medications on my behalf. A photo ID is required for prescription pickup. These individuals will be considered my emergency contacts. Without authorization, no information may be shared. I authorize Singleton Health Center to disclose my personal health information to the following people:  Name:	RELEASE OF INFORMATION			
DATE  EMAIL  F SIGNED BY LEGAL REPRESENTATIVE, RELATIONSHIP TO PATIENT  SIGNATURE OF WITNESS (Optional):  Disclosure to Family or Loved Ones: Emergency Contacts  I authorize Singleton Health Center to disclose my health care information and to discuss my health care needs to those that I designate. I further authorize the release of my billing information and give these individuals the ability to pick up prescriptions and/or medications on my behalf. A photo ID is required for prescription pickup. These individuals will be considered my emergency contacts. Without authorization, no information may be shared. I authorize Singleton Health Center to disclose my personal health information to the following people:  Name:  Relationship: Phone: Phone: Relationship: Phone: Phone:  CONSENT TO TREATMENT FOR ALL PATIENTS  I hereby grant authorization and consent for medical treatment and/or procedures for myself or the patient for whom I am the parent or legally authorized representative for which I am signing for, and understand that no guarantee or assurance has been made as to the results for which may be obtained. I agree to allow my provider to access all of my medication history including medications prescribed by other providers.  Patient Initials  AUTHORIZATION FOR E-PRESCRIBE  I hereby grant authorization to electronically submit prescriptions on my behalf. I also grant permission to access my prescription history from outside sources.  Patient Initials  NOTICE OF PRIVACY PRACTICES	<ul> <li>party. The third party may not be required to abide by thi health information.</li> <li>I may make a request in writing at any time to inspect and Federal Privacy Rule 45 CFR (164.524).</li> <li>my records are protected and cannot be disclosed without</li> </ul>	is Authorization or d/or obtain a copy written permission	applicable federal and state laws gover of my health information maintained at n	rning the use and disclosure of my
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Name:	Without authorization, no information may be shared. I at the following people:	uthorize Singleto	on Health Center to disclose my per	sonal health information to
Name:				
I hereby grant authorization and consent for medical treatment and/or procedures for myself or the patient for whom I am the parent or legally authorized representative for which I am signing for, and understand that no guarantee or assurance has been made as to the results for which may be obtained. I agree to allow my provider to access all of my medication history including medications prescribed by other providers.  Patient initials  AUTHORIZATION FOR E-PRESCRIBE  I hereby grant authorization to electronically submit prescriptions on my behalf. I also grant permission to access my prescription history from outside sources.  Patient initials  NOTICE OF PRIVACY PRACTICES	Name:	Relationship:	Phone: ()_	<del></del>
I hereby grant authorization and consent for medical treatment and/or procedures for myself or the patient for whom I am the parent or legally authorized representative for which I am signing for, and understand that no guarantee or assurance has been made as to the results for which may be obtained. I agree to allow my provider to access all of my medication history including medications prescribed by other providers.  Patient Initials  AUTHORIZATION FOR E-PRESCRIBE  I hereby grant authorization to electronically submit prescriptions on my behalf. I also grant permission to access my prescription history from outside sources.  Patient Initials  NOTICE OF PRIVACY PRACTICES	Name:	Relationship:	Phone: ()_	
legally authorized representative for which I am signing for, and understand that no guarantee or assurance has been made as to the results for which may be obtained. I agree to allow my provider to access all of my medication history including medications prescribed by other providers.  Patient Initials  AUTHORIZATION FOR E-PRESCRIBE  I hereby grant authorization to electronically submit prescriptions on my behalf. I also grant permission to access my prescription history from outside sources.  Patient initials  NOTICE OF PRIVACY PRACTICES	CONSENT TO TREATMENT FOR ALL PATIENTS			
AUTHORIZATION FOR E-PRESCRIBE  I hereby grant authorization to electronically submit prescriptions on my behalf. I also grant permission to access my prescription history from outside sources.  Patient initials  NOTICE OF PRIVACY PRACTICES	legally authorized representative for which I am signing results for which may be obtained. I agree to allow my process to the sum of the sum o	for, and unders	stand that no guarantee or assura	nce has been made as to the
I hereby grant authorization to electronically submit prescriptions on my behalf. I also grant permission to access my prescription history from outside sources.  Patient initials  NOTICE OF PRIVACY PRACTICES				
Patient initials  NOTICE OF PRIVACY PRACTICES	AUTHORIZATION FOR E-PRESCRIBE			
NOTICE OF PRIVACY PRACTICES		scriptions on my	behalf. I also grant permission to	access my prescription history
	NOTICE OF PRIVACY PRACTICES			
		of Privacy Pract	ices" today and agree with these p	rivacy policies.

Patient initials

# **PATIENT MEDICAL HISTORY**

Arthritis Cancer Diabetes Heart Problems Hypertension Stroke Thyroid Disorder SOCIAL HISTORY Marital status:   Single   Married   Divorced   Wildowed   Separated Occupation:   Rettred   Disabled (reason   Pack	*** Preferred Pharmacy:			
Suita Progs	☐ NONE/No Known Allergies ☐			
### Please indicate if any of your immediate relatives have had any of the following by placing an X in the appropriate box.  ### MOTHER	·	· · · · · · · · · · · · · · · · · · ·		
FAMILY HISTORY — Please indicate if any of your immediate relatives have had any of the following by placing an X in the appropriate box.  Arthritis	•			
MOTHER FATHER SIBLING (Brother/Sistar)  Arthritis  Cancer Diabetes Heart Problems Hypertension Stroke Thyroid Disorder Social History:  Social History:  Pes   No - Do you drink alcohol?   Dally   Weekly   Infrequently   Recovering Alcoholic   Pess   No - Do you drink alcohol?   Dally   Weekly   Infrequently   Recovering Alcoholic   Dally   Weekly   Infrequently   Recovering Alcoholic   Pess   No - Do you be tobacco?   Smoke   Dally   Weekly   Infrequently   Recovering Alcoholic   Dally   Recovering Alcohol		1 - 11 15 of your Immediate role		
Cancer Diabetes Diabe		MOTHER		SIBLING (Brother/Sister)
Diabetes Heart Problems Hypertension Stroke				
Heart Problems Hypertension Stroke Thyroid Disorder Surgical History: Have you ever had any of the following? NONE of the problems   chronic fatigue syndrome   hypogonadism male   pulmonary embolism/blood dot in least history asternial florillation   drug/acchol abuse   infection problems   shortness of breath   shortness of bre				
Hypertension Stroke Stroke Stroke SOCIAL HISTORY Marital status:   Single   Married   Divorced   Widowed   Separated Occupation:   Retired   Disabled (reason   Pattern   Patter				
Stroke   Thyroid Disorder   SCCIAL HISTORY				
Thyroid Disorder  SOCIAL HISTORY  Marital status:   Single   Married   Divorced   Widowed   Separated  Occupation:   Retired   Disabled (reason   Disabled (reason   Retired   Disabled (reason   Disabled (reason   Retired   Disabled (reason				
Marital status:   Single   Married   Divorced   Widowed   Separated				
Marital status: Single Married Divorced Widowed Separated Occupation: Retired Disabled (reason Disabled (reason Pees No - Do you drink alcohol? Dally Dwekly Directured Plasabled (reason Divos No - Do you use tobacco? Smoke packs per day) Chew  Surgical History: Please list any hospitalizations, surgeries, fractures or major Illnesses you have had.  TYPE OF SURGERY  Medical History: Have you ever had any of the Following? NONE of the problems listed allergies Chronic fatigue syndrome Phypogenadism male pulmonary embolism/blood dot in legative conditions depression problems problems situated diabetes infection problems situated sature diabetes infection problems situated status of bleeding problems erectile dysfunction infection problems situated stroke infection problems situated stroke infection problems situated stroke infection problems insurations of breath stroke infection problems insurations of breath stroke infection problems insurations stroke infection problems insurations of breath insurations of breath insurations of breath insurations of breath insurations insurations of breath insurations insurations insurations wheat allergy interiors and ingraines/headaches infections: List any medications: List any medications: List any medications you are currently taking (please include over the counter medications):  Medications you are currently taking (please include over the counter medications):  PLEASE PRINT LEGIBLY - NO CURSIVE PLEASE		1		
Occupation:				
Yes   No - Do you drink alcohol?   Dally   Meekly   Infrequently   Recovering Alcoholic   Yes   No - Do you use tobacco?   Smoke ( packs per day)   Chew   Chew   Surgicial History: Please list any hospitalizations, surgeries, fractures or major illnesses you have had.  TYPE OF SURGERY	<del>-</del>		•	
Yes   No - Do you use tobacco?   Smoke ( packs per day)   Chew	Occupation:		Retired Disabled (reason	)
Surgical History: Please list any hospitalizations, surgeries, fractures or major illnesses you have had.  TYPE OF SURGERY    Medical History: Have you ever had any of the following?   NONE of the problems listed   altergies   CHF congestive heart failure   hypertension   osteoporosis   anemia   chronic fatigue syndrome   hypogopradism male   pulmonary embolism/blood dot in legation   arthritis conditions   depression   hypothyroidism   setzure disorders   shortness of breath   arthritis conditions   diabetes   infection problems   shortness of breath   arthridis problems   erectile dysfunction   irritable bowel syndrome   stroke   BPH   fibromyalgia   kidney problems   syndrome X   stroke   syndrome X   cancer   heart disease   high cholesterol   meuropathy   cardiac arrest   high cholesterol   neuropathy   declarations   list any medications   list any medica	□Yes □No - Do you arink			olic
Medical History: Have you ever had any of the following?  NONE of the problems listed aftergies chronic fatigue syndrome				·
Medical History: Have you ever had any of the following?  NONE of the problems listed allergies   CHF congestive heart failure   hypertension   osteoporosis   anemia   chronic fatigue syndrome   hypothyroidism   seizure disorders   sastima   diabetes   infection problems   shortness of breath   insornnia   sinus conditions   depression   hypothyroidism   sinus conditions   shortness of breath   insornnia   sinus conditions   stroke   BPH   fibromyalgia   kidney problems   syndrome X   stroke   BPH   fibromyalgia   kidney problems   syndrome X   stroke   s		st any <u>hospitalizations</u> , <u>surgeries</u> , <u>r</u>	<u>fractures</u> or <u>major Illnesses</u> you nav	e had.
NONE of the problems listed   altergies   CHF congestive heart failure   hypertension   osteoporosis   anemia   chronic fatigue syndrome   hypogonadism male   pulmonary embolism/blood clot in le arthritis conditions   depression   hypothyroidism   seizure disorders   shortness of breath   arterial fibrillation   drug/alcohol abuse   infection problems   sinus conditions   bleeding problems   erectile dysfunction   irritable bowel syndrome   stroke   BPH   fibromyalgia   kidney problems   syndrome X   syndrome X   cancer   heart disease   migraines/headaches   wheat allergy   wheat allergy   medications; List any   caliac print   Legibly – No   cursive Please   curs	TYPE OF SURGERY			
following?  NONE of the problems listed altergies   CHF congestive heart failure   hypertension   osteoporosis   anemia   chronic fatigue syndrome   hypogonadism male   pulmonary embolism/blood clot in le arthritis conditions   depression   hypothyroidism   seizure disorders   asthma   diabetes   infection problems   shortness of breath   arterial fibrillation   drug/alcohol abuse   insomnia   sinus conditions   bleeding problems   erectile dysfunction   irritable bowel syndrome   stroke   BPH   fibromyalgia   kidney problems   syndrome X   CAD coronary artery disease   Gerd   menopause   tremors   cancer   heart disease   migraines/headaches   wheat allergy   cardiac arrest   high cholesterol   neuropathy   celiac disease   hyperinsulinemia   onychomycosis    Medications: List any medications you are currently taking (please include over the counter medications):  PLEASE PRINT LEGIBLY – NO CURSIVE PLEASE				
following?  NONE of the problems listed altergies   CHF congestive heart failure   hypertension   osteoporosis   anemia   chronic fatigue syndrome   hypogonadism male   pulmonary embolism/blood clot in le   arthritis conditions   depression   hypothyroidism   seizure disorders   asthma   diabetes   infection problems   shortness of breath   arterial fibrillation   drug/alcohol abuse   insomnia   sinus conditions   bleeding problems   erectile dysfunction   irritable bowel syndrome   stroke   BPH   fibromyalgia   kidney problems   syndrome X   CAD coronary artery disease   Gerd   menopause   tremors   cancer   heart disease   migraines/headaches   wheat allergy   cardiac arrest   high cholesterol   neuropathy   celiac disease   hyperinsulinemia   onychomycosis    Medications: List any medications): PLEASE PRINT LEGIBLY - NO CURSIVE PLEASE				
anemia chronic fatigue syndrome phypogonadism male pulmonary embolism/blood clot in le arthritis conditions depression phypothyroidism seizure disorders seizure disorders shortness of breath sinus conditions sinus conditions problems pro				· · · · · · · · · · · · · · · · · · ·
following?  NONE of the problems listed  altergies  chronic fatigue syndrome  hypogonadism male  arthritis conditions  depression  hypothyroidism  arterial fibrillation  drug/alcohol abuse  BPH  fibromyalgia  CAD coronary artery disease  cardiac arrest  cardiac arrest  high cholesterol  high cholesterol  hypogonadism male  hypothyroidism  hypothyroidism  seizure disorders  shortness of breath  sinus conditions  sinus conditions  stroke  syndrome  stroke  syndrome X  syndrome X  syndrome X  syndrome X  migraines/headaches  migraines/headaches  caliac disease  hyperinsulinemia  onychomycosis  Medications: List any  medications you are currently taking (please include over the counter medications):  PLEASE PRINT LEGIBLY - NO  CURSIVE PLEASE				
following?  NONE of the problems listed allergies anemia arthritis conditions asthma arterial fibrillation bleeding problems cAD coronary artery disease cardiac arrest car				
NONE of the problems listed   allergies   CHF congestive heart failure   hypertension   osteoporosis   allergies   chronic fatigue syndrome   hypogonadism male   pulmonary embolism/blood clot in le   arthritis conditions   depression   hypothyroidism   seizure disorders   seizure disorders   asthma   diabetes   infection problems   shortness of breath   arterial fibrillation   drug/alcohol abuse   insomnia   sinus conditions   stroke   BPH   fibromyalgia   kidney problems   syndrome   stroke   Syndrome   stroke   Syndrome   cancer   heart disease   migraines/headaches   wheat allergy   wheat allergy   wheat allergy   delications: List any medications you are currently taking (please include over the counter medications):  PLEASE PRINT LEGIBLY − NO CURSIVE PLEASE		ever had any of the		
□ allergies □ CHF congestive heart failure □ hypertension □ osteoporosis □ anemia □ chronic fatigue syndrome □ hypogonadism male □ pulmonary embolism/blood clot in less thriftis conditions □ depression □ hypothyroidism □ seizure disorders □ shortness of breath □ stroke □ shortness of breath □ sinus conditions □ insomnia □ sinus conditions □ sinus conditions □ sinus conditions □ stroke □ BPH □ fibromyalgia □ kidney problems □ stroke □ stroke □ stroke □ stroke □ cancer □ heart disease □ migralnes/headaches □ syndrome X □ tremors □ cardiac arrest □ high cholesterol □ neuropathy □ celiac disease □ hyperinsulinemia □ onychomycosis □ onychomycosis □ stroke □ hyperinsulinemia □ onychomycosis □ stroke □ hyperinsulinemia □ onychomycosis □ stroke □ syndrome X □ stroke □ migralnes/headaches □ wheat allergy □ wheat allergy □ stremors □ cardiac arrest □ high cholesterol □ neuropathy □ onychomycosis □ stroke □ syndrome X □ synd				
anemia chronic fatigue syndrome phypogonadism male pulmonary embolism/blood clot in legarithmitis conditions depression phypothyroidism seizure disorders seizure disorders shortness of breath sinus conditions sinus conditions problems pr		<del>-</del>	_	
□ arthritis conditions □ depression □ hypothyroidism □ seizure disorders □ asthma □ diabetes □ infection problems □ shortness of breath □ arterial fibrillation □ drug/alcohol abuse □ insomnia □ sinus conditions □ shortness of breath □ shortn				·
□ asthma □ diabetes □ infection problems □ shortness of breath □ arterial fibrillation □ drug/alcohol abuse □ insomnia □ sinus conditions □ stroke □ stroke □ BPH □ fibromyalgia □ kidney problems □ stroke □ syndrome X □ CAD coronary artery disease □ Gerd □ menopause □ tremors □ cancer □ heart disease □ migraines/headaches □ wheat allergy □ cellac disease □ hyperinsulinemia □ onychomycosis □ onychomycosis □ carcer □ hyperinsulinemia □ onychomycosis □ conter medications you are currently taking (please include over the counter medications):  PLEASE PRINT LEGIBLY – NO CURSIVE PLEASE □ disease □ infection problems □ shortness of breath □ sinus conditions		I I chronic fatigue syndrome	hypogonadism male	pulmonary embolism/blood clot in led
□ arterial fibrillation □ drug/alcohol abuse □ insomnia □ sinus conditions □ bleeding problems □ erectile dysfunction □ irritable bowel syndrome □ stroke □ BPH □ fibromyalgia □ kidney problems □ syndrome X □ CAD coronary artery disease □ Gerd □ menopause □ tremors □ cancer □ heart disease □ migraines/headaches □ wheat allergy □ cardiac arrest □ high cholesterol □ neuropathy □ celiac disease □ hyperinsulinemia □ onychomycosis  Medications: List any medications you are currently taking (please include over the counter medications):  PLEASE PRINT LEGIBLY – NO CURSIVE PLEASE			<b>□.</b>	
□ bleeding problems □ erectile dysfunction □ irritable bowel syndrome □ stroke □ BPH □ fibromyalgia □ kidney problems □ syndrome X □ CAD coronary artery disease □ Gerd □ menopause □ tremors □ cancer □ heart disease □ migraines/headaches □ wheat allergy □ cardiac arrest □ high cholesterol □ neuropathy □ celiac disease □ hyperinsulinemia □ onychomycosis  Medications: List any medications you are currently taking (please include over the counter medications):  PLEASE PRINT LEGIBLY – NO CURSIVE PLEASE	arthritis conditions	depression		seizure disorders
□ BPH □ fibromyalgia □ kidney problems □ syndrome X □ CAD coronary artery disease □ Gerd □ menopause □ tremors □ cancer □ heart disease □ migraines/headaches □ wheat allergy □ cardiac arrest □ high cholesterol □ neuropathy □ celiac disease □ hyperinsulinemia □ onychomycosis  Medications: List any medications you are currently taking (please include over the counter medications): PLEASE PRINT LEGIBLY – NO CURSIVE PLEASE	arthritis conditions asthma	<ul><li>depression</li><li>diabetes</li></ul>	infection problems	☐ seizure disorders☐ shortness of breath
□ CAD coronary artery disease □ Gerd □ menopause □ tremors □ cancer □ heart disease □ migraines/headaches □ wheat allergy □ cardiac arrest □ high cholesterol □ neuropathy □ celiac disease □ hyperinsulinemia □ onychomycosis □ onychomycosis □ hyperinsulinemia □ onychomycosis □ counter medications you are currently taking (please include over the counter medications):  PLEASE PRINT LEGIBLY – NO CURSIVE PLEASE	□ arthritis conditions     □ asthma     □ arterial fibrillation	<ul><li>depression</li><li>diabetes</li><li>drug/alcohol abuse</li></ul>	☐ infection problems☐ insomnia	☐ seizure disorders☐ shortness of breath☐ sinus conditions
□ cancer □ heart disease □ migraines/headaches □ wheat allergy □ cardiac arrest □ high cholesterol □ neuropathy □ celiac disease □ hyperinsulinemia □ onychomycosis  Medications: List any medications you are currently taking (please include over the counter medications): PLEASE PRINT LEGIBLY – NO CURSIVE PLEASE	<ul><li>□ arthritis conditions</li><li>□ asthma</li><li>□ arterial fibrillation</li><li>□ bleeding problems</li></ul>	<ul><li>depression</li><li>diabetes</li><li>drug/alcohol abuse</li><li>erectile dysfunction</li></ul>	<ul><li>☐ infection problems</li><li>☐ insomnia</li><li>☐ irritable bowel syndrome</li></ul>	☐ seizure disorders ☐ shortness of breath ☐ sinus conditions ☐ stroke
□ cardiac arrest □ high cholesterol □ neuropathy □ celiac disease □ hyperinsulinemia □ onychomycosis  Medications: List any medications you are currently taking (please include over the counter medications): PLEASE PRINT LEGIBLY – NO CURSIVE PLEASE	<ul> <li>□ arthritis conditions</li> <li>□ asthma</li> <li>□ arterial fibrillation</li> <li>□ bleeding problems</li> <li>□ BPH</li> </ul>	<ul> <li>depression</li> <li>diabetes</li> <li>drug/alcohol abuse</li> <li>erectile dysfunction</li> <li>fibromyalgia</li> </ul>	<ul> <li>☐ infection problems</li> <li>☐ insomnia</li> <li>☐ irritable bowel syndrome</li> <li>☐ kidney problems</li> </ul>	☐ seizure disorders ☐ shortness of breath ☐ sinus conditions ☐ stroke ☐ syndrome X
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medications you are currently taking (please include over the counter medications): PLEASE PRINT LEGIBLY - NO CURSIVE PLEASE	□ arthritis conditions     □ asthma     □ arterial fibrillation     □ bleeding problems     □ BPH     □ CAD coronary artery disease     □ cancer     □ cardiac arrest	□ depression □ diabetes □ drug/alcohol abuse □ erectile dysfunction □ fibromyalgia □ Gerd □ heart disease □ high cholesterol	☐ infection problems ☐ insomnia ☐ irritable bowel syndrome ☐ kidney problems ☐ menopause ☐ migraines/headaches ☐ neuropathy	☐ seizure disorders ☐ shortness of breath ☐ sinus conditions ☐ stroke ☐ syndrome X ☐ tremors
PLEASE PRINT LEGIBLÝ – NO CURSIVE PLEASE	□ arthritis conditions □ asthma □ arterial fibrillation □ bleeding problems □ BPH □ CAD coronary artery disease □ cancer □ cardiac arrest □ celiac disease	□ depression □ diabetes □ drug/alcohol abuse □ erectile dysfunction □ fibromyalgia □ Gerd □ heart disease □ high cholesterol	☐ infection problems ☐ insomnia ☐ irritable bowel syndrome ☐ kidney problems ☐ menopause ☐ migraines/headaches ☐ neuropathy	☐ seizure disorders ☐ shortness of breath ☐ sinus conditions ☐ stroke ☐ syndrome X ☐ tremors
MEDICATION	□ arthritis conditions □ asthma □ arterial fibrillation □ bleeding problems □ BPH □ CAD coronary artery disease □ cancer □ cardiac arrest □ celiac disease  Medications: List any medications you are currentl taking (please include over t	depression diabetes drug/alcohol abuse erectile dysfunction fibromyalgia Gerd heart disease high cholesterol hyperinsulinemia	☐ infection problems ☐ insomnia ☐ irritable bowel syndrome ☐ kidney problems ☐ menopause ☐ migraines/headaches ☐ neuropathy	☐ seizure disorders ☐ shortness of breath ☐ sinus conditions ☐ stroke ☐ syndrome X ☐ tremors
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## **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.

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, legal obligations, and your rights concerning your health information ("Protected Health Information" or "PHI"). We must follow the privacy practices that are described in this Notice (which may be amended from time to time). For more information about our privacy practices, or for additional copies o this Notice, please contact us using the information listed at the end of this Notice.

## USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION:

- a. Your PHI may be used and disclosed by the physician, our office staff and others outside our offices that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the business, and any other use required by law. We may use and disclose PHI without your written authorization for certain purposes as described below. The examples provided in each category are not meant to be exhaustive, but instead are meant to describe the types of uses and disclosures that are permissible under federal and state law.
  - i. Treatment: We may use and disclose PHI in order to provide treatment to you. For example, we may use PHI including your medication history, to diagnose, treat, and provide medical services to you. In addition, we may disclose PHI to other health care providers involved in your treatment.
  - il. Payment: Under federal law we may use or disclose PHI so that services you receive are appropriately billed to, and payment is collected from your health plan. By way of example, we may disclose PHI to permit your health plan to take certain actions before it approves or pays for treatment services. Under South Carolina state law, release of PHI to health plans require an authorization provided by you to us or to your health plan. We may contact the Guarantor for your visit in order to obtain payment.
  - III. Health Care Operations: We may use or disclose your PHI in order to support our business activities. These activities include, but are not limited to business associates, quality assessment activities, internal investigations, performance reviews, and training employees. In addition, we will use a sign in sheet at the registration desk where you will be asked to provide your name and date o birth. We may also call you by name in the waiting room when the physician is ready to see you. We may use or disclose your PHI to contact you to remind you of an appointment, to notify you of test results, to inform you of health-related services that may be of interest to you, and to check on your treatment, progress, and satisfaction with our services.
  - fv. Required of Permitted by Law: As required by law, Public Health issues as required by law, Communicable diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement Concerns, Funeral Directors, Organ Donation, Research, Criminal Activity, Milltary Activity, National Security, Worker's Compensation, Inmates and other required uses and disclosures. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services.
- b. Permissible Uses and Disclosures That May Be Made Without Your Authorization, But For Which You Have An Opportunity to Object
  - i. Family and Other Persons Involved in Your Care. We may use or disclose health information to notify or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience to make reasonable inference of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.
  - ii. Disaster Relief Efforts. We may use or disclose protected health information to a public or private entity authorized by law or it's charter to assist in disaster relief efforts for the purpose of coordinating notification of family members of your location, general condition, or death.
- c. Other Permitted and Required Uses and Disclosures: Use or Disclose of your PHI for marketing or sale of your PHI to third parties will be made only with your authorization. Once given, you may withdraw authorization at any time in writing.

#### II. YOUR INDIVIDUAL RIGHTS

- a. Right to Inspect and Copy. You may request access to your medical records and billing records maintained by us in order to inspect and request copies of the records. All requests to access must be made in writing. Under limited circumstances, we may deny access to your records. Under federal law, you may not inspect or copy psychotherapy notes, information complied in anticipation of, or use in a legal proceeding, and PHI that is otherwise prohibited. We may charge a fee for the costs of copying and sending you any records requested.
- b. **Right to Alternative Communications.** You may request, and we will accommodate, and reasonable written request for you to receive PHI by alternative means of communication or at alternative locations.
- c. Right to Request Restrictions. You may ask us not to disclose any part of your PHI for the purposes of treatment, payment, or health care operations. Your request must be in writing and state the specific restriction requested and to who you want the restriction to apply. If you have paid for your services in full and ask us not to disclose your visit to your insurance company, we will honor that request. We are not required to agree to any other restriction that you may request.
- d. **Right to Accounting of Disclosures.** Upon written request, you may obtain an accounting of certain disclosures of PHI made by us in the last six years. This right applies to disclosures for purposes other than treatment, payment, or health care operations, excludes disclosures made to you or disclosures otherwise authorized by you, and is subject t other restrictions and limitations. We are required by law to notify you if your unsecured PHI is breached.
- e. Right to Request Amendment. You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances. If we deny your written request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and provide you with a copy of any such rebuttal.
- f. Right to Obtain Notice. You have the right to obtain a paper copy of this Notice by submitting a request to the center's Compliance Officer at any time.
- g. Questions and Complaints. If you desire further information about your privacy rights, or are concerned that we have violated your privacy rights, you may contact the center's Compliance Officer. You may also file a written complaint with the Director, Office for Civil Rights of the U.S. Department of Health and Human Services. We will not retaliate against you if you file a complaint with the Director or with our office.

#### III. EFFECTIVE DATE AND CHANGES TO THIS NOTICE

a.

- Effective Date. The Notice is effective on January 01, 2020.
- b. Changes to this Notice. We may change the terms of this Notice at any time. If we change this Notice, we may make the new notice terms effective for all PHI that we maintain, including any information created or received prior to issuing the new notice. If we change this Notice, we will post the revised notice in the waiting area of our office and on our website. You may also obtain any revised notice by contacting the center's Compliance Officer.