CHARLESTON ONCOLOGY

COMPASSIONATE CARE FOR CANCER AND BLOOD DISORDERS

A Department of Bon Secours St. Francis Hospital

2085 Henry Tecklenburg Dr. 2nd Floor
Charleston, SC 29414
843.577.6957 Ph.
843.577.6523 Fax

2910 Tricom Street
North Charleston, SC 29406
843.572.9211 Ph.
843.572.0457 Fax

125 Doughty St., Suite 500
Charleston, SC 29403
843.577.2276 Ph.
843.723.3324 Fax

3510 Highway 17 North, Suite 300
Mt. Pleasant, SC 29466
843.420.1530 Ph.
843.388.5480 Fax

300 Callen Blvd., Suite 110
Summerville, SC 29486
843.572.9211 Ph.
843.572.0457 Fax

302 Medical Park Dr, Suite 207B
Walterboro, SC 29488
843.572.9211 Ph.
843.572.0457 Fax

Dear _____

Welcome to Charleston Oncology, a Department of Bon Secours St. Francis Hospital! We consider it a privilege that you have entrusted us with your health care.

This letter is to confirm your appointment with Dr. _____.

For you to be ready to see the physician at this time, it is important for you to come to the office 30 minutes before your scheduled appointment. Your physician may need additional blood work or additional paperwork before you see him/her.

Enclosed is a new patient packet, which we would appreciate you completing before your appointment and bringing with you. This will speed up the registration process.

Here are a few things you will need to bring with you:

- Current insurance card(s) and photo identification.
- Any medical records in your possession.
- A current list of your medications. Please bring your bottles of medication with you.
- Payment if you are covered by Medicare or private insurance and have not met your deductible or your co-payment if one is required.

If you have concerns about fees, billing procedures, or need financial assistance please contact Ensemble at (888) 472-0043.

If you are unable to keep your scheduled appointment or have any questions, please call the phone number for your scheduled location any time between 8:30 am and 5:00 pm Monday through Friday.

Sincerely,

Charleston Oncology

Patient# (office use only) _____

Date: _____

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Patient's Name: _____
First Middle Last ☐ Single ☐ Widow

Social Security No: _____ Race: _____ Sex: M F Marital Status: ☐ Married ☐ Divorced

Ethnicity: Hispanic ☐ yes ☐ no ☐ non-specified
Are you in a skilled nursing facility? ☐ yes ☐ no
Are you currently enrolled in Hospice care? ☐yes ☐ no
Do you have an Advanced Directive or Living Will? ☐yes ☐ no

Address: _____
No/Apt. Street City State Zip

Home Phone: _____ Work Phone: _____

Age: _____ Date of Birth: _____ Email Address: _____

Patient's Employer: _____
name & address of company

Spouse's Name: _____ Date of Birth: _____

Spouse's Social Security No: _____ Phone: _____

Person Responsible if other than patient: _____ Relationship to Patient: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Referred by: _____ Primary Care Physician: _____

Primary Insurance Information: _____
Name of Insured

_____ _____ _____
Insurance Company Name ID Number Group No.

Secondary Insurance Information: _____
Name of Insured

_____ _____ _____
Insurance Company Name ID Number Group No.

By signing this consent, you:

accept personal responsibility for all services rendered to you. If your insurance company does not pay for the service(s) rendered, you accept personal responsibility for the amount not covered by insurance.

authorize payment of medical benefits to Charleston Oncology for any medical and/or surgical services rendered to you.

authorize this office to release any information acquired during an examination and treatment to your insurance company.

authorize your physician or designated, qualified assistants to provide you with medical treatment. You consent to all medical or diagnostic care ordered for you. This consent includes testing for infections such as hepatitis B and HIV and providing blood or body fluids for such tests to protect you and/or those who provide you services.

I believe the above information is correct to the best of my knowledge.

_____ _____
Patient Signature Date

_____ _____
Responsible Party Signature Date

CHARLESTON ONCOLOGY
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AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name _____ **Date of Birth** _____

Address _____

City, State, Zip _____

Please list the names of any person authorized to receive medical information concerning the patient:

_____ _____
_____ _____
_____ _____

Initial each method you authorize the above person(s) to receive patient information:

_____ Voicemail
_____ E-mail
_____ Phone conversation

Description of information to be released (Initial those that apply):

_____ Date and time of my next appointment and with whom
_____ Information results from any test or x-rays
_____ Other information as described:_____

This authorization shall be in force and in effect until revoked by the patient or representative signing the authorization.

RIGHTS OF THE PATIENT

I UNDERSTAND THAT I HAVE THE RIGHT TO REVOKE THIS AUTHORIZATION AT ANY TIME BY SENDING A WRITTEN NOTIFICATION TO: ADMINISTRATOR, 2085 HENRY TECKLENBURG DRIVE 2ND FLOOR, CHARLESTON, SC 29414.

I UNDERSTAND THAT INFORMATION USED OR DISCLOSED AS A RESULT OF THIS AUTHORIZATION MAY BE SUBJECT TO REDISCLOSURE BY THE RECIPIENT AND MAY NO LONGER BE PROTECTED BY FEDERAL OR STATE LAW.

I UNDERSTAND THAT I HAVE THE RIGHT TO INSPECT OR COPY THE PROTECTED HEALTH INFORMATION TO BE USED TO DISCLOSE AS DESCRIBED IN THIS DOCUMENT. I CAN DO THIS BY WRITTEN NOTIFICATION TO: ADMINISTRATOR, 2085 HENRY TECKLENBURG DRIVE 2ND FLOOR, CHARLESTON, SC 29414.

I UNDERSTAND THAT MY TREATMENT WILL NOT BE CONDITIONED ON SIGNING THIS AUTHORIZATION.

I UNDERSTAND THAT I HAVE THE RIGHT TO REFUSE TO SIGN THIS AUTHORIZATION.

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Print Name of Patient or Personal Representative Date

CHARLESTON ONCOLOGY
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Medical History

Name:_____ **Age:**_____ **Date:** _____

Referring Physician:_____

Other Physicians:_____

Chief Complaint: Please explain the reason why you are here today:_____

_____

_____

✓ Check if YES

- ☐ Alcoholism
- Anemia
- Angina
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Blood Clots
- ☐ Cataracts
- ☐ Chronic bronchitis
- ☐ Colitis
- ☐ Colonoscopy, Date_____
- ☐ Crohn's Disease
- ☐ Cystitis (Bladder Infection
- Depression
- ☐ Diabetes
- ☐ Diverticular Disease/Polyp
- Drug Abuse
- ☐ Emphysema
- ☐ Gallbladder Disease
- ☐ Glaucoma
- ☐ GYN Problems
- ☐ Heart Attack
- ☐ Heart Disease/Murmur
- ☐ Hepatic Disease
- ☐ Hepatitis
- Hiatal Hernia
- ☐ High Blood Pressure
- ☐ High Cholesterol
- HIV
- Irregular Heartbeat
- ☐ Kidney Infection
- ☐ Lupus
- ☐ Multiple Sclerosis
- Other Collagen Vascular Disease
- ☐ Parkinson's Disease
- ☐ Prostate Disease
- ☐ Pancreatitis
- ☐ Psychiatric Treatment
- ☐ Rheumatoid Arthritis
- ☐ Scleroderma
- ☐ Seizures/Epilepsy
- ☐ Severe Anxiety
- Skin Conditions
- ☐ Stroke/Paralysis
- ☐ Thyroid Disease or Goiter
- Tuberculosis
- ☐ Ulcers

List other Medical Problems of Past Surgeries (Include approximate dates):_____

_____

_____

_____

Have you ever Had:

Any other cancer? Yes No If yes, please explain: _____

_____

Previous Radiation treatments? Yes No If yes, please explain: _____

_____

Previous Chemotherapy? Yes No If yes, please explain: _____

_____

Are you currently under home health or hospice care? ∆ Home Health ∆Hospice

Name: _____

Family History

Has anyone in your family had cancer? ☐Yes ☐ No If Yes, please list type and relationship:

_____

_____

Social History

Occupation:_____

Marital Status: ☐Married ☐Divorced ☐Separated ☐Single ☐Widow(ed)

Name of Spouse or Significant other:_____

Does a principle care person live with you? ☐ Yes ☐ No Children(#):_____

Is this person willing to help? ☐Yes ☐No Ages:_____

Health of Principle Care Person:_____

Current Living Conditions: ☐Live Alone ☐ Live with family/others

Live in: ☐House ☐ Nursing/Personal care Home ☐ Assisted living

Do you have… (If yes please explain)

Transportation problems? ☐ Yes ☐ No _____

Religious Preference (Optional)? ☐ Yes ☐ No _____

Any special requirements/disability? ☐ Yes ☐ No _____

Financial/Homecare Needs? ☐ Yes ☐ No _____

Living Will? ☐ Yes ☐ No **Do you want info?** ☐ Yes ☐ No

Smoke Cigarettes? ☐ Yes ☐ No ☐ In the Past **Packs per day:**_____

When did you quit?_____ **Years Smoked:**_____

Drink Alcohol? ☐ Yes ☐ No **Frequency?** ☐ Occasional ☐ Moderate ☐ Heavy

Female Gynecologic History

Age at first menstrual period:_____ **Age of final Menstrual period, if applicable:**_____

Have you had irregular bleeding? ☐ Yes ☐ No **Do you take birth control?** ☐ Yes ☐ No

Hormone Replacement Therapy: ☐ Yes ☐ No ☐ In the Past

Pregnancies (#):_____ **Live Births (#):**_____ **Miscarriages (#):**_____

Living Children (#):_____ **Age at first childbirth:**_____

Breast Feeding? ☐ Yes ☐ No **Was this your first Breast Biopsy?** ☐ Yes ☐ No

Are you currently pregnant? ☐ Yes ☐ No ****If yes, notify doctor or nurse****

Medication History

Pharmacy:_____ Phone #:_____

Please list medication currently using prescribed, over the counter, herbal, or recreational:

Medication	**Dosage**	**How Often?**	**Prescribing Doctor?**
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

During the course of treatment, please inform the nurse of any changes to your medications

Have you received an influenza vaccination (flu season only)? ☐ Yes ☐ No

Allergies

Allergy to X-ray dye? ☐ Yes ☐ No **Allergy to drugs?** ☐ Yes ☐ No

Allergy to Foods? ☐ Yes ☐ No **Other Allergies?** ☐ Yes ☐ No

List Allergies/ Describe Reaction:

_____

_____

_____

_____

_____

Pain Assessment

Do you have Pain? ☐ Yes ☐ No

Please rate your pain today? 1- Being no pain and 10- extreme pain _____

What pain medicines or other methods do you use to relieve pain? _____

_____

Is there any other information that you feel is important for us to know? _____

_____

Review of Systems

✓ Please Check all that apply

Constitutional

- ☐ **Fever**
- ☐ **Chills**
- ☐ **Night Sweats**
- ☐ **Loss of Appetite**
- ☐ **Fatigue**
- ☐ **Weight Gain**
- ☐ **Weight Loss**
- ☐ **Other:_____**

Eyes

- ☐ **Change in Vision**
- ☐ **Loss of Vision**
- ☐ **Cataracts**
- ☐ **Contacts**
- ☐ **Glasses**
- ☐ **Other:_____**

Ears

- ☐ **Change in Hearing**
- ☐ **Deafness**
- ☐ **Ringing in ears**
- ☐ **Other:_____**

Nose

- ☐ **Nasal Stuffiness**
- ☐ **Bleeding**
- ☐ **Sinus Congestion**
- ☐ **Other:_____**

Mouth

- ☐ **Dentures**
- ☐ **Dental Problems**
- ☐ **Ulcers/Sores**
- ☐ **Other:_____**

Throat

- ☐ **Sore Throat**
- ☐ **Difficulty Swallowing**
- ☐ **Hoarseness**
- ☐ **Other:_____**

Cardiovascular

- ☐ **Chest Pain**
- ☐ **Irregular Heartbeat**
- ☐ **Pacemaker**
- ☐ **Fainting Spells**
- ☐ **Swelling in Legs**
- ☐ **Cold Extremities**
- ☐ **Intermittent lower leg calf pain when walking**
- ☐ **Other:_____**

Musculoskeletal

- ☐ **Bone Pain**
- ☐ **Joint Pain**
- ☐ **Artificial Joints**
- ☐ **Leg Pain when walking**
- ☐ **Other:_____**

Respiratory

- ☐ **Shortness of Breath**
- ☐ **Shortness of Breath on Exertion**
- ☐ **Cough**
- ☐ **Chest Pain**
- ☐ **Coughing up Blood**
- ☐ **Require Oxygen**
- ☐ **Other:_____**

Gastrointestinal

- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Blood in Stools
- ☐ Abdominal Pain
- ☐ Difficulty Swallowing
- ☐ Pain with Swallowing
- ☐ Hemorrhoids
- ☐ Yellowing of Skin
- ☐ Change in Stools
- ☐ Other:_____

Endocrine

- ☐ Change in Thirst
- ☐ Frequent Urination
- ☐ Thyroid Problem
- ☐ Other:_____

Skin

- ☐ Rashes
- ☐ Sores
- ☐ Changes in Moles
- ☐ Lumps
- ☐ Other:_____

Psychiatric

- ☐ Depression
- ☐ Anxiety
- ☐ Nervousness
- ☐ Sleep Problems
- ☐ Other:_____

Genitourinary: Male

- ☐ Frequency of Urination
- ☐ Urgency of Urination
- ☐ Urinating Frequently at Night
- ☐ Straining with Urination
- ☐ Painful Urination
- ☐ Blood in Urine
- ☐ Sexual Dysfunction
- ☐ Leaking of Urine
- ☐ Other:_____

Genitourinary: Female

- ☐ Frequency of Urination
- ☐ Urgency of Urination
- ☐ Urinating Frequently at Night
- ☐ Straining with Urination
- ☐ Painful Urination
- ☐ Blood in Urine
- ☐ Sexual Dysfunction
- ☐ Leaking of Urine
- ☐ Abnormal Vaginal Bleeding
- ☐ Painful Intercourse
- ☐ Other:_____

Breasts

- ☐ Lump
- ☐ Nipple Discharge
- ☐ Skin Changes
- ☐ Pain
- ☐ Other:_____

Hematologic/Lymphatic

- ☐ Bruising
- ☐ Bleeding
- ☐ Enlarged Lymph Nodes
- ☐ Other:_____

Neurologic

- ☐ Headache
- ☐ Numbness
- ☐ Tingling
- ☐ Weakness
- ☐ Seizures
- ☐ Dizziness
- ☐ Difficulty Speaking
- ☐ Paralysis
- ☐ Unsteady Gait
- ☐ Recent Falls
- ☐ Loss of Bladder Control
- ☐ Loss of Bowel Control
- ☐ Other:_____

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Roper Cancer Center
2085 Henry Tecklenburg Dr. 2nd Floor
Charleston, SC 29414
843.577.6957 Ph. 843.577.6523 Fax

Trident Professional Park
2910 Tricom Street
North Charleston, SC 29406
843.572.9211 Ph. 843.572.0457 Fax

Roper Medical Office Building
125 Doughty St., Suite 500
Charleston, SC 29403
843.577.2276 Ph.843.723.3324Fax

Mount Pleasant Hospital
3510 Highway 17 North, Suite 300
Mt. Pleasant, SC 29466
843.420.1530 Ph. 843-388-5480 Fax

Roper Berkley Medical Office
300 Callen Blvd, Suite 110
Summerville, SC 29486

Colleton MedShare
302 Medical Park Drive, Suite 207B
Walterboro, SC 29488

Emergency Care

We are available twenty-four (24) hours a day, seven (7) days a week for any emergencies that might arise. Should you feel it is urgent that you contact us, you may call the office number, **843-577-6957/843-572-9211 or toll free 866-376-4629** at any time of the day or night.

When the office is closed, our answering service will answer your call and refer you to Dr. Ellison, Dr. Geils, Jr, Dr. Holladay, Dr. Jeter, Dr. Keogh, Dr. Lingerfelt, Dr. Michaelsen, Dr. Orcutt, Dr. Gene Saylors, Dr. Julia Saylors, Dr. Schmidt, or Dr. Shand.

Patients on chemotherapy: If your temperature reaches 100.5 (or higher) when taken by mouth you **MUST** call your physician. **Do not hesitate** to call regardless of the time of day or day of the week, an oncologist is always on call and will be happy to help you!

Should you feel that the situation is so urgent that you must get to the hospital immediately, we request that you go to Roper, St. Francis, Roper Mt. Pleasant Hospital, or Trident Emergency Room. The necessary telephone numbers are:

Roper Emergency Room – 843-724-2010
St. Francis Emergency Room – 843-402-1037
Roper Mt. Pleasant Emergency Room – 843-606-7535
Trident Hospital Emergency Room -843-797-7000
Roper Berkeley Hospital Emergency Room -843-529-3100
Emergency Medical Service – 911

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Attention Patients and Caregivers:

NO SHOW POLICY

Effective June 1, 2015, Charleston Oncology will be implementing a No-Show Policy to better serve all of our patients and ensure that everyone receives timely and appropriate care. Please take a moment to review the details of this policy:

Cancellation: If you must cancel your appointment, we kindly request that you do so at least 24 hours prior to your scheduled appointment. This allows us to offer that time slot to another patient in need of medical attention.

Late Arrivals: Patients who arrive more than 30 minutes late for their scheduled appointment may be asked to reschedule. We aim to provide the best care to all of our patients, and punctuality is an important part of this process.

Consecutive No-Shows: After two consecutive no-shows, you will receive a warning letter to remind you of the importance of adhering to your appointments.

No-Show Fee: After three consecutive no-shows, a $25 no-show fee will be applied to your account. This fee helps cover the costs associated with missed appointments.

Termination of Care: After four consecutive no-shows, you will receive a letter of termination. This means that you will be discharged from our care, and we will be unable to continue providing medical services to you.

Exceptions: Please note that this policy will not apply to patients who are admitted as inpatients, or to those whose appointments are scheduled by our outside scheduling department. We kindly request that you notify us if your appointment is coordinated by an external entity so that we can accommodate you effectively into our schedule.

We understand that life can be unpredictable, and we always aim to be as flexible as possible to accommodate your needs. However, this policy is designed to ensure that we can provide high-quality care to all of our patients and effectively manage our appointment schedule.

If you have any questions or concerns regarding this policy, please do not hesitate to reach out to our office, and our team will be happy to assist you.

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Chart #_____

FINANCIAL POLICY AGREEMENT

Welcome to the medical practice of Charleston Oncology. We want to inform you of our financial policies prior to your treatment to prevent any misunderstanding; it is our belief that addressing any financial concerns regarding your treatment upfront and as soon as possible is a critical part of your care. If this agreement does not answer any questions you have concerning our financial policies, please do not hesitate to speak with an insurance representative at our practice.

To help us provide the best service possible, complete, accurate, and up-to-date insurance information is a necessity at each visit to the office.

- Insured patients: As a courtesy to you, our patient, we will submit claims to your primary, secondary and/or tertiary insurance plan on your behalf. Insurance coverage varies considerably from plan to plan and we must rely on you to inform us of the appropriate filing order and any special rules your plan requires.
- **Your deductible, out of pocket, co-payment and co-insurance is due at the time of service unless other arrangements have been made in advance.**
- Uninsured patients: Full payment is due at the time of service. We may be able to offer a discount based on income. Please ask to speak with a Financial Counselor to see if you qualify for a hardship discount.
- If you are unable to pay in full at the time of service, a payment plan agreement may be arranged through a Financial Counselor. This arrangement must be made in advance.
- We will verify your insurance coverage at every visit. Please understand that oncology/hematology claims can be very costly and our extra attention to insurance verification is to limit your chance of receiving a large, unexpected bill.
- We do our best to let you know what your approximate cost will be for services and/or treatments, but it is only an ***ESTIMATE***. The true final cost will be determined by your insurance carrier.
- When labs, x-rays or other tests are ordered by Charleston Oncology, you are responsible for notifying us if your insurance requires these tests be performed at a specific location.
- Patients requiring referral authorizations must contact our office prior to making arrangements for health care or testing outside of our practice. Any unauthorized charges will be your responsibility.
- We make every attempt to enroll every patient on drug cost assistance programs. You may be required to complete forms and provide proof of finances, i.e., tax documents or social security statements. If you fail to complete the forms and provide the requested information within 30 days, you will be liable for the full balance.
- We accept cash, checks, American Express, Discover, Visa and MasterCard.

By signing this consent, I agree to:

- Accept personal responsibility for all services rendered to me.
- Authorize payment of medical benefits to Charleston Oncology for any medical and/or surgical services rendered to me.
- Authorize Charleston Oncology to release any information required in the course of my examination and treatment to my insurance company to assist them in paying my claims.

I have read, understood and agree to the Financial Policy (above).

_____ _____
Signature of Patient Date

_____ _____
Printed Patient Name Date

Received by: _____

Date: _____

CHARLESTON ONCOLOGY
COMPASSIONATE CARE FOR CANCER AND BLOOD DISORDERS
A Department of Bon Secours St. Francis Hospital

Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name: _____Date of Birth:_____

I have reviewed a copy of the Notice of Privacy Practices for the above named practice or have received a copy upon request.

_____ _____

Signature Date

CHARLESTON ONCOLOGY
COMPASSIONATE CARE FOR CANCER AND BLOOD DISORDERS
A Department of Bon Secours St. Francis Hospital

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:
Dax Arrington
2085 Henry Tecklenburg, Suite 200
Charleston, SC 29414

We are required by law to maintain the privacy of your personal health information and to provide you with notice of our legal duties and privacy practices related to your personal health information. This Notice of Privacy Practices describes how we may use and disclose your personal health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your personal health information. "Personal health information" is information, including demographic information (such as your age or your address), that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services or payment for such services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all personal health information that we maintain at that time. You may obtain a copy of any revised Notice of Privacy Practice by calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

1. Uses and Disclosures of Personal Health Information. Your personal health information 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. Your personal health information may also be used and disclosed to pay your health care bills and to support the operations of our practice. Other uses and disclosures may be made by our practice if you are given an opportunity to object to the use or disclosure or with your express authorization.

Examples of the types of uses and disclosures of your protected health care information that our office is permitted to make are explained below. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

We will not provide a copy of your medical records to another person for any of the purposes described below without your express written consent except as explained in this Notice of Privacy Practices.

A. Uses and Disclosures for Treatment, Payment and Practice Operations:

1. **Treatment:** We may use and disclose your personal health information for our own treatment purposes or the treatment purposes of another health care provider. Treatment activities include the provision, coordination, or management of your health care and any related services. For example, we may disclose your personal health information, as necessary, to other physicians who may be treating you

2. **Payment:** Your personal health information may be used or disclosed to obtain payment for the health care services we provide to you or for the payment purposes of another health care provider. For example, we may disclose your personal health information to your health plan to obtain approval for services. We may provide a copy of your medical records to your health plan without your express written consent if your health plan has a written authorization on file torelease medical information to the health plan.

3. **Healthcare Operations**: We may use or disclose your personal health information to support the business activities of our practice. These business activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing and fundraising activities, conducting or arranging for consulting services, and business planning activities. We may also disclose your personal health information to another entity that is subject to the federal privacy protections to conduct certain business activities including quality assessments and improvement activities, reviews of the qualifications of health care professionals, evaluating provider performance or health care fraud and abuse detection or compliance.

   We may disclose your personal health information to third party "business associates" that perform various activities for the practice such as billing services, our answering service and transcription services. Whenever an arrangement between our office and a business associate involves the use or disclosure of your personal health information, we will have a written contract that contains terms that are intended to protect the privacy of your personal health information.

   We may also use or disclose your personal health information to remind you of your appointments with the practice. In addition, we may use or disclose your personal health information to provide you with information about treatment alternatives or other health-related benefits and services that are offered by our practice that may be of interest to you.

B. Uses and Disclosures of Personal Health Information With Your Written Authorization:

Uses and disclosures of your personal health information other than for treatment, payment or healthcare operations purposes will be made only with your written authorization, unless we are otherwise permitted or required by law to use or disclose your personal health information

as described below. You may revoke an authorization, at any time, in writing, except to the extent that we have already taken an action based on the use or disclosure permitted by the authorization.

C. Permitted and Required Uses and Disclosures with an Opportunity to Object: We may use and disclose your personal health information in the instances described below. You will be given the opportunity, when possible, to agree or object to the use or disclosure of all or part of your personal health information. If you are not present or able to agree or object to the use or disclosure of the personal health information, then your physician may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the personal health information that is relevant to your health care will be disclosed.

1. **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 you identify, your personal health information that directly relates to that person's involvement in your health care. 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 your physician's professional judgment.

2. **Notification Purposes:** We may use or disclose personal 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.

3. **Disaster Relief:** We may use or disclose your personal health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate with disaster relief agencies.

D. Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or an Opportunity to Object: We may use or disclose your personal health information in the following situations without your authorization or without giving you an opportunity to object to the use or disclosure. These situations include:

1. **Required By Law:** We may use or disclose your personal health information to the extent that the use or disclosure is 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.

2. **Public Health:** We may disclose your personal health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure may be made for the purpose of controlling disease, injury or disability. For example, we may disclose your personal health information to public health authorities that are authorized by law to notify a person who may have been exposed to a communicable disease or may otherwise

be at risk of contracting or spreading the disease or condition. We may also disclose your personal health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

3. **Health Oversight:** We may disclose personal 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.

4. **Abuse or Neglect:** We may disclose your personal health information to a public health authority that is authorized by law to receive reports of child or vulnerable abuse or neglect. In addition, we may disclose your personal health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws and you will be informed of the report except in certain limited circumstances.

5. **Food and Drug Administration:** We may disclose your personal health information to a person or company required by the United States Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track products; enable product recalls; make repairs or replacements, or conduct post marketing surveillance.

6. **Legal Proceedings:** We may disclose personal health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized) and in certain conditions in response to a subpoena, discovery request or other lawful process.

7. **Law Enforcement:** We may also disclose personal health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of the practice, and (6) in a medical emergency (not on the practice's premises) when it is likely that a crime has occurred.

8. **Coroners, Funeral Directors, and Organ Donation:** We may disclose personal 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. We may also disclose personal health information to a funeral director, as authorized by law, in order to permit the funeral director to carry

out their duties. We may disclose such information in reasonable anticipation of death. Personal health information may also be used and disclosed for cadaveric organ, eye or tissue donation purposes.

9. **Research:** We may disclose your personal health information to researchers when their research has been approved by an institutional review board or appropriate privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your personal health information.

10. **Criminal Activity:** Consistent with applicable federal and state laws, we may disclose your personal health information if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose personal health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

11. **Military Activity and National Security:** When the appropriate conditions apply, we may use or disclose personal health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your personal health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

12. **Workers' Compensation:** Your personal health information may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally-established programs.

13. **Inmates:** We may use or disclose your personal health information if you are an inmate of a correctional facility, your physician created or received your personal health information in the course of providing care to you and the disclosure of the information is necessary for your care, the health and safety of other inmates or correctional personnel or the administration of the correctional facility.

E. Required Uses and Disclosures: We are required by law to make disclosures to you upon request. We are also required to make disclosures of your personal health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of the federal privacy requirements.

2. Your Rights. As a patient of this practice, you have certain rights related to your personal health information. The following information explains how you may exercise these rights.

A. You have the right to inspect and copy your personal health information. This means you may inspect and obtain a copy of personal health information about you that is contained in a designated record set for as long as we maintain the personal health information. A "designated record set" contains medical and billing records and any other records that your physician and the practice use for making decisions about you. You must submit a written request to the CEO at 2085 Henry Tecklenburg, Suite 200, Charleston, SC 29414, to inspect or copy your personal health information. We have the right to charge you a reasonable fee for a copy of your medical record.

Under law, however, you may not inspect or copy the following records: (1) psychotherapy notes that are maintained separately from your medical record; (2) information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and (3) personal health information that is subject to law that prohibits access to personal health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact the Privacy Officer if you have questions about access to your medical record.

B. You have the right to request a restriction of your personal health information. This means you may ask us not to use or disclose any part of your personal health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your personal health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Our practice is not required to agree to a restriction that you may request. If we believe it is in your best interest to permit use and disclosure of your personal health information, your personal health information will not be restricted. If we agree to a restriction requested by you, we may not use or disclose your personal health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician. The practice may terminate its agreement to a restriction by providing you with written notice. Requests for restrictions must be submitted in writing to your physician in care of the "CEO" at 2085 Henry Tecklenburg, Suite 200, Charleston, SC 29414.

C. You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests to receive confidential communications of your personal health information. We may condition this accommodation by asking you for information as to how payment will be handled or to specify an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to

the Privacy Officer at 2910 Tricom Street, Charleston, S.C. 29406.

D. You may have the right to have your physician amend your personal health information. This means you may request an amendment of personal health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a response to your statement and will provide you with a copy of our response. Please contact the Privacy Officer at 2910 Tricom Street, Charleston, S.C. 29406 if you have questions about amending your medical record.

E. You have the right to receive an accounting of certain disclosures we have made, if any, of your personal health information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures made prior to April 14, 2003, and disclosures we make after April 14, 2003, that are (1) pursuant to an authorization; (2) to you, (3) to family members or friends involved in your care, (4) incidental to other permitted disclosures, (5) for national security purposes, (6) for inmates to correctional institutions, (7) part of a limited data set that does not include any direct identifiers and that is subject to an agreement that protects the confidentiality of the personal health information, or (8) for notification purposes. You have the right to receive specific information regarding these disclosures that occur after April 14, 2003 for a period of up to six (6) years. You may request a shorter timeframe. The right to receive this information is subject to certain exceptions, restrictions and limitations.

F. You have the right to obtain a paper copy of this notice from us. Even if you have agreed to accept this notice electronically, we will furnish a copy of this Notice of Privacy Practices upon request.

3. Complaints. You may submit a complaint to us if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying the CEO at 2085 Henry Tecklenburg, Suite 200, Charleston, SC 29414, of your complaint. We will not retaliate against you for filing a complaint.

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

This Notice of Privacy Practices was published and becomes effective on June 1, 2008.