Dear Patient,

On behalf of all the staff, I welcome you to our office. We are pleased that you have selected us to care for your healthcare needs. We want you to know that we are committed to providing you with courteous, compassion and education you on your condition while respecting your privacy.

During your first visit we will conduct a thorough examination. The exam will included a discussion of your medical history and the reason you are visiting us. Your doctor will then discuss his diagnosis and the suggested treatment with you. This visit is a consultation; a procedure will not be done on your first visit with us.

Enclosed you will find a New Patient Packet, which includes the following documents,

1. Patient Demographics Information
2. A History and Physical Questionnaire
3. Authorization to Release Information Form: to give permissions for telephone messages, work excuses, school excuses, and an option for you to give specific permission to any family member or friend you wish to designate to participate in your healthcare with our office.
4. Office Policies and Patient Responsibilities
5. Notice of Privacy Practices
6. Acknowledgement Form for the Notice of Privacy Practices
7. Directions to our office

Please read and complete the packet in its entirety and bring it with you to your appointment. Also, do not forget to bring your insurance card and picture id, and any medical records that pertain to the reason of your visit. On the day of your visit, please come prepared to pay a co-insurance, co-pay or deductible that may apply to this office visit. A pre-authorization or referral may be required due to your insurance requirements. If possible, please arrive 15 minutes early so we can go over your information and any questions you may have.

Should you any questions before your visit, please feel free call us. We look forward to seeing you on your schedule appointment. If you cannot make the appointment that has been scheduled for you, please contact our office at least 48 hours before your scheduled appointment time to reschedule or cancel.

Sincerely,

Siva K. Chockalingam, M.D.

Enclosures

PATIENT INFORMATION

Date: _____ Primary Care Doctor: _____ Referring Doctor: _____

Patient Name: _____ **Date of Birth: _____ SSN _____Circle here if refuse**

Address: _____

City: _____ State: _____ Zip Code: _____

Home No._____Cell No._____ Work No._____

Can we E-mail you? If so what is your email address: _____@_____.com or .net .mil

Marital Status: (please circle): Married Widowed Divorced Single Sex (please circle): Male Female

Race: Circle One: Asian African American Caucasian Hispanic American Indian or Alaska Native

Native Hawaiian or Other Pacific Islander Unknown Patient declines to specify

Your Employment Status: (please circle) **Active Retired Disabled Unemployed**

Your Employer: _____City: _____

Work Phone No. _____ Occupation: _____

Are you in Hospice? _____Yes _____No

Emergency Contact (Not currently living with you): _____ _____

Relationship to Patient: _____ Phone: _____

PRIMARY Insurance:_____Contract/I.D._____Group No.:_____

Policyholder Name: _____Relationship: _____Date of Birth: _____

Social Security No. _____Employer: _____

SECONDARY Insurance: _____Contract/I.D: _____ Group No.: _____

Policyholder Name: _____Relationship: _____Date of Birth: _____

Social Security No. _____Employer: _____

PERSON RESPONSIBLE FOR THE BILL:

Name _____ Date of Birth _____ SSN: _____

Address if different than patient: _____

Relationship with patient: _____

Pharmacy Name: _____City:_____ Pharmacy Phone: _____

Authorization- Compound

This authorization form permits: Associates In Gastroenterology, P.A. to use or disclose protected health information listed in the Description section below to the Entity or Person listed in the Receiving Entity section for the following patient:

Name _____ **Birth Date** _____

Receiving Entity: Please check the boxes for those entities or persons you wish to get the described information about you.	Description of information to be given to checked Entity or Person.
Voice mail Home #_____	☐ Appointment time ☐ Results of lab test or x-rays ☐ Other _____
Voice mail Business # _____	☐ Appointment time ☐ Results of lab test or x-rays ☐ Other _____
Voice mail Cell phone #_____	☐ Appointment time ☐ Results of lab test or x-rays ☐ Other _____
Employer _____ School _____	☐ Appointment or absentee information ☐ Return to work or school information
Spouse (Provide name) _____ Telephone Number:_____	☐ Family billing information ☐ Financial information ☐ Medical information- please list _____
Parent (Provide name) _____ Telephone Number:_____	☐ Family billing information ☐ Financial information ☐ Medical information- please list _____ _____
Other (Please provide name) _____ Relationship _____ Telephone Number:_____	☐ Financial information ☐ Medical information- please list _____ _____

Purpose - The purpose of this authorization is to meet the patient's request for information disclosures and uses and to obtain the consent below.

Consent for Patient Reminders and Notifications

You are consenting to receive messages from us, your healthcare provider, Siva K. Chockalingam, M.D. that utilizes an automatic telephone dialing system to deliver a text, voice, or pre-recorded message that may contain health related information or healthcare management advice at the telephone number(s) that you have provided. You understand that you are not required to provide consent in order to receive such information or advice from your healthcare provider.

Terms & Conditions

Your request to receive automated voice and text messages from us, your healthcare provider, constitutes your agreement to these terms and conditions. You agree that we may send you automated voice and text messages through your wireless provider to the valid mobile or landline number that you have provided us. You agree to indemnify, defend, and hold us, our technology service vendor – healow LLC, our electronic medical record vendor – eClinicalWorks LLC, and its affiliated companies harmless from any third-party claims, liability, damages or costs arising from your request to receive automated voice or text messages or from providing us, your healthcare provider, with a phone number that is not your own. You agree that we and our technology solution vendors will not be liable for failed, delayed, or misdirected delivery of, any information sent to you or from you, including opt-out requests. You must be 18 years or older in order to participate or have the express permission of a parent/guardian (but in any case, you must be at least 13 years old). This is a standard-rate messaging program where **message and data rates may apply. Frequency of messages may vary depending on the number of messages that you are due to be sent by your healthcare provider.**

Supported carriers include AT&T, Verizon Wireless, T-Mobile®, Metro PCS®, Sprint, Boost, Virgin Mobile, U.S. Cellular®, and others. Additional carriers may be added at any time. Carriers are not liable for delayed or undelivered messages. T-Mobile® is not liable for delayed or undelivered messages.

Frequently asked questions:

What sort of messages can we send you?

As your healthcare provider, our goal is to stay in touch with you even when you're not in their office. To keep the lines of communication open and based on need, we can send you messages via voice SMS/text, email and secure messages on the Patient Portal and using healow. Example of communication from our practice can include: appointment reminders, prescription refill messages and health/wellness notifications for tests or other procedures. We respect your need for privacy and will not send you telemarketing related messages or share your contact details with anyone.

What does it mean when you opt-in or activate?

By choosing to opt-in for voice and or text messages from us, your healthcare provider office, you are consenting to receive phone, text and/or other electronic messages to the number we have on file for you. We have chosen to use this automated service reminders offered by healow and eClinicalWorks. Please direct all your communication directly with us, your healthcare provider office and not our technology vendor companies. **Please note**: Phone, emails and text messages are considered unsecure methods of contact and may result in disclosure of sensitive information to unauthorized individuals. You are assuming the risk involved by activating these services and will not hold the practice responsible.

Can you turn off these services later?

Yes, simply contact us, your healthcare provider office and ask to adjust your communication preferences. You can also text **STOP** on reply to a text message that you receive from us. **On texting STOP**, your phone number will be unsubscribed from this service and you will not receive any further health and wellness messaging notifications via text.

What if you need further help?

Please note that these services are either simply to remind you of important or necessary steps that you need to take for living a better healthier lifestyle or for offering you convenient ways to connect with us, your healthcare provider outside the walls of their clinic. If there is ever an emergency or if you need help, please call 911 or call our offices during regular working hours right away. Should you need additional help **text HELP** on reply to a text message and access the same message.

Did you know simple steps you take can protect your health information online?

Password protect any device from which you view or download your health information, both on your mobile phone or home computer. Make sure your password meets the criteria for a strong secure password which means it consists of a at least six characters and uses a combination of letters, numbers, and symbols. Also, if you are using a public computer to access your health information, be sure to log out.

Talk or text you soon!

Associates In Gastroenterology, P.A. with phone number 803-788-1100

Berkeley Endoscopy Center, L.L.C. with phone number 803-788-1120

Ether, L.L.C. with phone number 803-719-5253

Expiration date or event: This authorization shall be enforce until revoked by the patient or _____

Verification method or code: This practice will verify the identity of any entity requesting protected health information. Verification information may include: _____**social security, date of birth, address, last appointment.**

Rights of the Patient - I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

I understand that I have the right to revoke this authorization at any time by sending a written notification to the address listed at the top of this form I understand that a revocation is not effective in cases where the information has already been used or disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

_____Date _____

Signature of Patient or Personal Representative (as defined by HIPAA)

Welcome to Associates In Gastroenterology. This brochure is designed to provide you with helpful information about our policies and procedures of operations. If you have questions regarding any of the policies below please contact our Office Manager. The cost of care is expensive and a financial policy is a part of every medical practice.

Patient Responsibilities and Financial Policy

Patients are ultimately responsible for all charges for services provided by Associates In Gastroenterology and payment is due when services are rendered.

If a procedure is scheduled, a non-refundable deposit may be required. This deposit will be applied to any deductible or co-pay that needs to be met.

We have the right to deny any treatment that is determined a non-emergency by our physicians due to for any outstanding balance.

We accept payments by cash, personal check, debit card, VISA and MasterCard.

Insured Patients

As a courtesy, we will file your primary, secondary and tertiary insurance. If we participate with your insurance company, any amount due after the applicable contractual adjustment will be your responsibility.

Please provide us with the most updated and current information necessary to file the claim. If this is not obtained on the date of service rendered, you may be responsible for your bill. You are also responsible for notifying us of any changes in insurance. A copy of your card is required at each visit. If you do not have your card at the time of the visit, you will be asked to sign a waiver and may be billed for the services.

Please call your insurance company, if you need to verify that our office and physicians participate with them. Different insurance companies have different co-pays and deductibles. Please be aware of your individual policy requirements. You are required to pay your co-pay and/or deductible at the time of your visit with us.

We do participate with Medicare and will file insurance that is secondary to Medicare. It is your responsibility to pay your co-insurance and/or deductible at the time of service.

We are also a participating provider for SC Medicaid; however, you must have your current card at the time of service. Your card must have remaining visits left to be valid. Please verify with our office regarding our participation with any HMO Medicaid Plan.

It is the patient's responsibility to provide us with the primary care physician referral form. Please check to see if your insurance requires a referral and verify that it is obtained before your visit. If a referral is required, but not obtained, full payment may be required from the patient at the time of service.

Assignment of Benefits and Release of Record

As a patient of our office, you agree to assign and authorize payment directly to Associates In Gastroenterology of all benefits for facility charges for services rendered by the facility.

If your insurance carrier has NOT paid your claim in full within 60 days, please call your insurance company to inquire about the status.

THE PRACTICE EMPLOYEES ARE NOT ABLE TO DEFINE YOUR INSURANCE COVERAGE

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NON-INSURED PATIENTS

All non-insured patients are able to have a discount for prompt payment and it is expected to be paid at the time of service. We do NOT offer payment plans.

Attendance, Cancellation and Missing Appointment Policy

Office Visits: If you cannot make a scheduled appointment, it must be cancelled at least one (1) business day in advance. Patients who fail to give one (1) business day notice will be considered a "no-show" and may be assessed a charge of $25.

Procedures: All cancellations for procedures MUST be received within three (3) business days. Failure to notify the office may result in a $50 cancellation fee.

Charges for Procedures

We strive to provide you with cost-effective, high quality care. You may receive four (4) separate bills:

1. Physician's technical component fee from Associates In Gastroenterology
2. The facility fee from Berkeley Endoscopy Center
3. If a biopsy is taken during the procedure, the Pathology/lab services will be billed separately. The pathologist is a doctor who reviews the tissue specimens or labs collected from your procedure. (If X-rays are ordered after the procedure, the radiologist will bill you separately for these services.)
4. Ether, L.L.C., for the anesthesia administered to you by the Certified Registered Nurse Anesthetist at the Endoscopy Center.

Returned check

There is a $35.44 charge in the event your check is returned for any reason. Our Financial Coordinator will notify you in writing and with a courtesy phone call.

Collections

We, AIG and Ether, L.L.C. reserve the right to send accounts with a balance over 60 days old to an outside collection agency. The agency does have the right to report the past due balance to the credit bureau. Should the account be referred to an attorney or collection agency, you agree to reimburse us the fees of any collection agency, which may be based on a percentage at a maximum of 30% of the debt, and all costs, and expenses, including reasonable attorneys' fees, we incur in such collection efforts. As the patient, you certify that you- the Insured or Guarantor- are financially responsible.

Office Policies

Your care will be provided by your Physician and Medical Assistant. The Medical Assistant will help coordinate your care under the direction of your physician. The Assistant will schedule follow up appointments, procedures, blood tests, and radiology services, as well as call in prescriptions and attend to your calls. Please direct all of your concerns to the Medical Assistant. The Physician personally makes his calls which can be placed any hour of the day. It is very difficult for a physician to make or take calls during a high volume clinic day.

Without your complete and current medical information, you are at risk of a misdiagnosis. It is in your best interest to provide us with your complete medical information. You do not have to waste time filling out forms in the waiting room! All the doctors you see are required to provide one copy of your record at no charge to you.

Our office hours are: Monday thru Thursday from 8:00 am to 5:00 pm.
Phone hours are: 8:30 am to 4:45 pm.

We are closed on the following holidays:

Memorial Day, Fourth of July, Labor Day, Thanksgiving Day and the next day, Christmas Eve at 12pm, Christmas Day, New Year Eve at 12pm and New Year's Day**.**

Patient Portal

We now have electronic health medical record software that offers time saving efforts for you. You will be asked to provide us with an email address so you may start utilizing the portal on your **personal computer** or downloading an App called **Healow** from your **Smartphone**. This portal will enable you to make and cancel appointments, update your medications, request medication refills, access your medical records, and ask the staff and physicians questions. Get started now!!!!

Prescriptions---- Bring your medication list with you at every appointment!

We only send prescription refills electronically; you can request a refill by using the Patient Portal, provided your account is in good standing. Please allow 48 hours to process your request. Certain prescriptions may require additional authorization from your insurance company and this may take an additional business days. If you choose not to use the Patient Portal and leave a message, it is your responsibility to provide your Date of Birth and name of medication. We only use the pharmacy that you provided to us upon your initial check in and it remains on file. Please be aware that NOT all requests will be approved; it is the discretion of the physician. The physician may need to see you for an appointment if it has been awhile since your last visit with us.

Test Results

Our physicians are very concerned with giving results over the phone for a number of reasons; mainly, because it is not the most secure way to communicate. When patient and physician are face to face the communication is more effective and provides the opportunity to see reports, pictures and films. With that being said, the overall care has greatly improved. Please understand your care is our priority even though this policy may seem frustrating for you and your loved ones.

Medical Records

You are entitled to get copies of your medical records. As per South Carolina Law, Section 44-115-80 you will be charged as follows. There is a $15 processing fee plus $0.65 per page for copies up to 30 pages and $0.50 per page more than 30 pages. There will be no charge for medical records that are sent directly to your provider. Medical records will be released only after a signed Medical Release Form is directly sent to us from your Primary Care Physician. Your request will be processed within 5 business days after payment is received.

Disability & Family Medical Leave Act

For your benefit we complete medical forms such as Disability, Leave of Absence, FMLA, etc. There is a $25.00 processing fee that will need to be submitted with the form. Your request will be processed within 5 business days after payment is received.

I have acknowledged and read the above policies regarding my financial and Patient Responsibilities.

Patient Name: (Print) _____ Date: _____

Patient/ Responsible Party and/or Legal Guardian Signature: _____

11/18/14

Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge that I have received the Notice of Privacy Practices for the above office.

_____

Signature: Patient's Name / Personal Representative (as defined by HIPAA) Date

_____

Description of Personal Representation and please attach copy of documentation.

Documentation of "Good Faith" Attempt to get acknowledgement signature.

- ☐ Document presented to patient, but patient refused to sign acknowledgement.
- ☐ Patient presented with an emergency situation and there was no time to give the Notice or receive a signature. Attempt to get give the Notice, and get any acknowledgement will be handled as soon as possible.
- ☐ Documentation was presented to the patient but a communication failure prevented us from receiving the acknowledgement.
- ☐ The documentation was mailed to the patient but never returned to us.
- ☐ Other _____
  _____

Name:_____Reason for Today's Visit: _____Date:_____

FOR OFFICE USE ONLY:

WEIGHT:	**PULSE:**	**Colonoscopy:**
HEIGHT:	**O2:**	**Endoscopy:**
BP:	**Pharmacy:**	**Egg Allergy:**

MEDICATIONS: If you have a medication list, please give to receptionist to copy for you.

No.	Name of Medications	Dose	How often
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			

ALLERGIES

No.	Name	Reaction
1		
2		
3		
4		

MEDICAL HISTORY:

No.	Specialist	Name	Phone Number	Fax Number
1	Primary Care Physician			
2	Cardiologist			
3	Pulmonologist			

(Please circle any conditions that you may have)

No.	Condition	Additional Information
1.	Seizures	
2.	Depression	
3.	Parkinson's Disease	
4.	Stroke	
5.	Anxiety	
6.	Bipolar	
7.	Arrhythmia	Pacemaker / Defibrillator / Blood thinners
8.	Coronary Heart Disease	Stent When: _____/ Blood thinners
9.	Heart Value Replacement	Mechanical or Pig Value? When:_____Blood thinners
10.	Aortic Aneurysm	
11.	Hypertension	
12.	Asthma	Inhaler / Nebulizer / Prednisone / Home Oxygen
13.	COPD	Home oxygen / Nebulizer / Prednisone
14.	Pulmonary embolism	
15.	Sleep Apnea	CPAP?
16.	Pulmonary Hypertension	
17.	Leg Clot (DVT)	When: _____ Blood thinners
18.	Sickle Cell Anemia	
19.	Anemia: Low Iron	
20.	Diabetes	Do you take Insulin?
21.	Cancer	Location:
22.	Renal Failure	Dialysis?
23.	Glaucoma	
24.	Cataract	Surgery?
25.	Arthritis	
26.	Endometriosis	
27.	Adhesions	
28.	HIV	
29.	Hepatitis	A / B / C
30.	Thyroid	Over active or Underactive
31.	Cholesterol	

SURGICAL HISTORY: ( ) NONE

No.	Date (Month/Year)	Surgery
1		
2		
3		

HOSPITAL ADMIT / EMERGENCY ROOM VISIT: ( ) NONE

No.	Date (Month/Year)	Reason for visit
1		
2		
3		

FAMILY HISTORY:

No.	Relationship		Information - Circle the answer
1	Mother		Alive / Deceased / Unknown? Colon cancer? _____
2	Father		Alive / Deceased / Unknown? Colon cancer? _____
3	Brothers	#_____	Alive / Deceased / Unknown? Colon cancer? _____
4	Sisters	#_____	Alive / Deceased / Unknown? Colon cancer? _____
5	Sons	#_____	Alive / Deceased / Unknown? Colon cancer? _____
6	Daughters	#_____	Alive / Deceased / Unknown? Colon cancer? _____
7	Paternal Grandparent		Alive / Deceased / Unknown? Colon cancer? _____
8.	Maternal Grandparent		Alive / Deceased / Unknown? Colon cancer? _____

SOCIAL HISTORY:

No.	Agent	Information
1	Tobacco: No	Yes: 1. How often do you smoke cigarettes? Every day or some days
		2. How many cigarettes a day do you smoke?
		3. How soon after you wake up do you smoke your first cigarette?
		4. Are you interested in quitting?
2	Alcohol: No	Yes: 1. How often did you have a drink containing alcohol in the past year?
		a. Daily
		b. Weekly
		c. Monthly
		2. How many drinks did you have on a typical day when you were drinking in the past year?
		a. 1 drink
		b. 3 drinks
		c. 5 drinks
		d. 7 drinks
		e. 9 drinks
		3. How often did you have 6 or more drinks on one or more occasions in the past year?
		a. Never
		b. Daily
		c. Weekly
		d. Monthly
3	Drugs: No	Yes: 1. What type of drugs?
		a. Marijuana
		b. Crack
		c. Cocaine
		d. Heroine
		e. Methamphetamine

IMMUNIZATIONS: ( ) NONE

Date (Month/Year)	
	Hepatitis A
	Hepatitis B
	Flu Shot
	Pneumonia
	HPV
	PPD / TB
	Tetanus

REVIEW OF SYSTEMS— ARE YOU HAVING ANY OF THE FOLLOWING SYMPTOMS? Please circle

General / Constitutional:	**Confusion**
	Fatigue
	Fever
	Weight loss
Ophthalmologic	**Cataracts**
	Blurred Vision
	Discharge
	Itching and redness
Ear / Nose / Throat	**Hoarseness**
	Decreased hearing
	Dry mouth
	Sinus trouble
Respiratory	**Cough**
	Shortness of breath at rest
	Wheezing
Cardiovascular	**Chest pain at rest**
	Dizziness
	Irregular heartbeat
	Palpitations
Gastrointestinal	**Exposure to HIV**
	Gas
	Abdominal pain
	Exposure to Hepatitis
Genitourinary	**Blood in urine**
	Difficulty urinating
	Painful urination
Musculoskeletal	**Knee pain**
	Muscle aches
	Sciatica
	Swollen joints
Skin	**Bruises easy**
	Hives
	Itching
	Rash
Neurologic	**Numbness**
	Loss of strength
	Seizures
Psychiatric	**Anxiety**
	Depressed mood
	Substance Abuse
	Suicidal thoughts

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.

Uses and disclosures to carry out treatment, payment, and health care operations

Treatment- This practice may use or disclose your protected health information in consultation between health care providers relating to your treatment or for your referral to another health care provider for your treatment.

Payment- This practice may use or disclose your protected health information for billing, claims management, collection activities, or obtaining payment.

Health care Operation- This practice may use or disclose your protected health information for reviewing the competence or qualifications of health care professionals, or for conducting training programs in which students, trainees, or practitioners participate. This practice may use or disclose your protected health information for accreditation, certification, licensing, or credentialing activities. This practice may use or disclosure your protected health information to our business associates who participate in our healthcare operations. These disclosures will only be made after we have satisfactory assurances in the form of a Business Associates Agreement from the business associate. These assurances will include their agreement to comply with the HIPAA rules and the compliance of any subcontractor with which they do business.

Authorized Uses or Disclosures

The following uses or disclosures require a valid authorization as defined by the HIPAA standards.

Uses or Disclosures for Psychotherapy Notes- Not applicable to this practice

Uses or Disclosures for Marketing Purposes- Not applicable to this practice-with permission face to face.

Disclosures for a Sale of Protected Health Information- This practice will require an authorization for any disclosures that would constitute a sale of protected health information.

For any other use or disclosure you wish us to make, you can give us a written, valid authorization. Your authorization must have specific instructions for the use and disclosure you want us to make. You will have the right to revoke the authorization in writing at any time before the information is used or disclosed.

Uses or disclosures requiring an opportunity for the individual to agree or object

For disclosures to others involved with your health care or payment, we will inform you in advance and give you the opportunity to agree or object. These disclosures will be limited to the information necessary to help with your health care or payment. These disclosures will only be made if you do not object.

Uses and disclosures for which an authorization or opportunity to agree or object is not required

The following uses or disclosures do not require an authorization or the opportunity for you to agree or object.

Uses and disclosures required by law-This practice may use or disclose protected health information to the extent required by law. The use or disclosure will comply with and be limited to the relevant requirements of such law.

Uses and disclosures for public health activities-This practice may use or disclose protected health information for the purpose of preventing or controlling disease, injury, or disability, including, but not limited to, the reporting of disease, injury, and vital events such as birth or death.

Disclosures about victims of abuse, neglect or domestic violence
This practice may disclose protected health information about an individual whom this practice reasonably believes to be a victim of abuse, neglect, or domestic violence.

Uses and disclosures for health oversight activities-This practice may disclose protected health information to a health oversight agency for oversight activities authorized by law, including audits, civil, administrative, or criminal investigations, inspections, licensure, or disciplinary actions.

Disclosures for judicial and administrative proceedings- This practice may, in response to an order of a court or administrative tribunal, provide only the protected health information expressly authorized by such order or a subpoena.

Disclosures for law enforcement purposes- This practice may disclose protected health information as required by law including laws that require the reporting of certain types of wounds or other physical injuries.

Uses and disclosures about decedents- This practice may disclose protected health information to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death, or other duties as authorized by law. We may disclose protected health information to a funeral director, as authorized by law, to carry out their duties. This disclosure will be made in reasonable anticipation of death.

Uses and disclosures for cadaveric organ, eye or tissue donation purposes- This practice may use or disclose protected health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of cadaveric organs, eyes, or tissue for the purpose of facilitating organ, eye or tissue donation and transplantation.

Uses and disclosures for research purposes- This practice may use or disclose protected health information for research, when the research has been approved by an institutional review board or privacy board, to protect your protected health information.

Uses and disclosures to avert a serious threat to health or safety- This practice may, consistent with applicable law and standards of ethical conduct, use or disclose protected health information, in good faith, if we believe 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.

Uses and disclosures for specialized government-This practice may use and disclose the protected health information of individuals who are Armed Forces personnel for activities deemed necessary by appropriate military command authorities to assure the proper execution of the military mission, if the appropriate military authority has published by notice in the Federal Register.

Disclosures for workers' compensation-This practice may disclose protected health information as authorized by and to the extent necessary, to comply with laws relating to workers' compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

Patient rights under HIPAA

The following information describes your rights under the HIPAA Standards. This practice requires that all requests for the various rights be made in writing and we will provide our decision on your request in writing. You should be aware that there may be some situations when there could be limitations placed on your rights. We are required to permit you to request these rights, but we are not required to agree to your request, except as discussed in the Right of Restriction section**.**

Right of an individual to request a restriction of uses and disclosures
This practice will permit an individual to request that we restrict uses or disclosures of protected health information about the individual to carry out treatment, payment, or health care operations or to others involved in your care or in payment. We will consider these requests, but we are not required to agree to them, except as discussed in the next section.

Under your right of restriction, you may restrict certain disclosures of protected health information to a health plan for payment or healthcare operation, where payment in full is made out of pocket for a healthcare item or service

Confidential communication requirements

This practice will permit an individual to request and will accommodate reasonable requests to receive communications of protected health information from our practice by alternative means or at an alternative location.

Access of individuals to protected health information

An individual has a right of access to inspect and obtain a copy of protected health information about the individual in a designated record set except as prohibited by state or federal law or certain other exemption. Your access may be provided in electronic form if producible at your request or in another form or format. As permitted by state and federal law, we may charge you a reasonable cost based fee for a copy of your record. Questions about the fee should be addressed to our Privacy Officer at the phone number listed at the end of this document.

Amendment of protected health information

An individual has the right to ask to have this practice amend protected health information or a record about the individual in a designated record set for as long as the protected health information is maintained in the designated record set.

Accounting of disclosures of protected health information

An individual has a right to receive an accounting of disclosures of protected health information made by this practice in the past six years but not before April 14, 2003. The accounting will not include disclosures made for treatment, payment, or operations, as well as authorized disclosures or disclosures made for which you had an opportunity to agree or object. You may receive one free accounting in a 12 month period. There will a reasonable cost based fee for additional requests.

Right of Breach Notification
An individual has the right to and will receive a notification of any breach of their unsecured protected health information as defined by the Breach Notification Rule. We will fulfill our obligation to provide notice in accordance to HIPAA standards.

Copy of this notice

You have a right to a copy of this notice. Even if you agreed to receive an electronic copy, you may request and receive a paper copy.

Our Duties

This practice is required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices with respect to protected health information.

This practice is required to abide by the terms of the notice currently in effect.

This practice is required to notify you of any change in a privacy practice that is described in the notice to protected health information that we created or received prior to issuing a revised notice. We reserve the right to change the terms of our notice and to make the new notice provisions effective for all protected health information that we maintain. Revised Notices with be available and posted at our offices(s) and posted on our web site, if applicable.

Complaints

If at any time you feel we have violated your HIPAA rights, please contact our Privacy Officer or the Secretary of Health and Human Services. This practice will not retaliate against any individual for filing a complaint.

Contact

You have the right to file a complaint with our Privacy Officer at the address and phone number at the top of this notice, or with the Office of Civil Rights, US Department of Health and Human Services,
61 Forsyth St., SW, Suite 3B70, Atlanta, GA 30323.

Effective Date of the Notice is ____4/24/2013_____

Directions to Columbia office from:

1. ***N.E. Columbia***: Go toward I-20 on Clemson Rd., take a right onto Wildewood Centre Drive at the Shell Gas Station/Dunkin Donuts.

We are the last building on the right hand side of the road:

1070 and 1072 Wildewood Centre Drive

2. ***N.W. Columbia***: Take I-20 toward Florence, get off on Exit 80 Clemson Rd. Take a left on Clemson Rd., at the first traffic light, then take a left onto Wildewood Centre Drive at the Shell Gas Station/Dunkin Donuts.

We are the last building on the right hand side of the road:

1070 and 1072 Wildewood Centre Drive.

3. ***Camden***: Take I-20 W towards Columbia, take Exit 80 to Clemson Rd., and turn right onto Clemson Rd. get into the far left hand lane at the traffic light turn left at the Shell Gas Station/Dunkin Donuts on to Wildewood Centre Drive.

We are the last building on the right hand side of the road:

1070and 1072 Wildewood Centre Drive

4. ***Sumter***: Take 378 to 601 North. Take a left onto Screaming Eagle Rd. into Pontiac. Then take I-20 W towards Columbia, take Exit 80 to Clemson Rd. turn right onto Clemson Rd. get into the far left hand hand lane, then turn left at the Shell Gas Station/Dunkin Donuts on to Wildewood Centre Drive.

We are the last building on the right hand side of the road:

1070 and 1072 Wildewood Centre Drive

Sumter: Take 521 to Camden, get on I-20 W towards Columbia. Take Exit 80 to Clemson Rd. Turn right onto Clemson Rd. get into the far left hand lane and turn left at the Shell Gas Station/Dunkin Donuts on to Wildewood Centre Drive.

We are the last building on the right hand side of the road at:

1070 and 1072 Wildewood Centre Drive

5. ***Lexington:*** Take I-20 E towards Florence, take Exit 80 to Clemson Rd., turn left onto Clemson Rd. at the first traffic light, and turn left at the Shell Gas Station/Dunkin Donuts on to Wildewood Centre Drive.

We are the last building on the right hand side of the road at:

1070 and 1072 Wildewood Centre Drive