LOWCOUNTRY WELLNESS CENTER

Lowcountry Wellness Center
1941 Savage Road, 100E
Charleston, SC 29407
P: 843-793-1353 | F: 843-818-4172
www.lowcountry-wellness.com

Your Information. Your Rights. Our Responsibilities.

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.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

➤ ***See page 2*** *for more information on these rights and how to exercise them*

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

➤ ***See page 3*** *for more information on these choices and how to exercise them*

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

➤ ***See pages 3 and 4*** *for more information on these uses and disclosures*

Your Rights

When it comes to your health information, you have certain rights.
This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.
Ask us to limit what we use or share	• You can ask us **not** to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. • If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on page 1. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** • We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

continued on next page

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as:
	  • Preventing disease
	  • Helping with product recalls
	  • Reporting adverse reactions to medications
	  • Reporting suspected abuse, neglect, or domestic violence
	  • Preventing or reducing a serious threat to anyone's health or safety

Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you:
	  • For workers' compensation claims
	  • For law enforcement purposes or with a law enforcement official
	  • With health oversight agencies for activities authorized by law
	  • For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Revised: 08/24/2019

This Notice of Privacy Practices applies to the following organizations.

Lowcountry Wellness Center LLC

Acknowledgment of Privacy Practices

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Patient Name:_____ Date of Birth ___/___/___

Signature:_____

Date_____

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Section L. Entire Agreement; Amendment

This Agreement contains the entire Agreement between the parties and may be amended only by a written Agreement signed by the parties.

Section M. Paragraph Headings; Gender

Any titles, captions or headings in this Agreement are for convenience only and are not part of this Agreement. References to gender include the masculine and feminine, as appropriate.

_____	_____
Patient Signature	Date
_____	_____
Lowcountry Wellness Center, LLC	Date

Lowcountry Wellness Center LLC

CONTROLLED SUBSTANCES ACKNOWLEDGEMENT FORM

Your Nurse Practitioner may prescribe certain controlled substances for You from time to time as she deems medically appropriate. However, Your Nurse Practitioner does not treat chronic pain and does not provide chronic pain management. As such, any controlled substances that may be prescribed to You will be prescribed on a limited, short-term basis. Should You require long-term, chronic pain management, Your Nurse Practitioner will refer You to a provider to treat Your chronic pain and/or will assist You in transferring Your care and treatment to the provider of Your choice.

By signing below, You understand and acknowledge that neither Your Nurse Practitioner nor the Practice provides long-term pain management/treatment services and that You will not be prescribed any controlled substances on a long-term basis. You further agree to inform Your Nurse Practitioner of all controlled substances that are prescribed to You by any other provider and acknowledge that this is an on-going obligation on Your part as a Patient of the Practice.

_____ Date:_____
Patient/Legal Representative Signature

_____
Print Patient Name

_____ _____
Print Legal Representative Name Relationship to Patient

_____ Date:_____
Patient/Legal Representative Signature

_____
Print Patient Name

_____ _____
Print Legal Representative Name Relationship to Patient

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Send out Lab/Referral Form

As a patient of Lowcountry Wellness Center, LLC, you are important to us. It is important you understand that your visit doesn't end when you leave here today. We want you to get the follow-up you deserve. **We need your help to make sure this happens.**

- If the Nurse Practitioner has ordered a referral for you to see a specialist or to get an outside x-ray, you will be notified within a week with the date of the appointment.
    - A) If you choose to skip the appointment or procedure, this clinic will not be responsible for the outcome.
    - B) It is your responsibility to reschedule the appointment if you cannot go when you are originally scheduled.
- If you have had lab drawn at the time of your visit, you can expect to hear from it within a week.
    - A) If lab is drawn Monday through Wednesday, you will usually receive your results that week. If your lab is drawn Thursday through Sunday, you will receive your results the following week.
    - B) Patients will receive results on their lab work as soon as possible if the results are critical.
    - C) Some lab work takes longer than others.
    - D) We do not call patients on Saturday or Sunday with results. Please do not call us on these days for your results.

If you have not heard from us within a week regarding any of the above, you should call us at 843.793.1353.

If we have tried to call you and you don't have a voice mail on your phone, you don't have any minutes left, or you don't answer, or you don't call us back, we will only try 3 times before mailing the results to the address you have given the front office when you checked in.

Never assume that because you have not heard from us that everything is OK!!

_____ _____

Patient Signature/Acknowledge Date

MAKO
MEDICAL LABORATORIES

Patient Signature On File Form

Section 1: *Patient Information*

Name: _____

Address: _____

City: _____ State: _____ Zipcode: _____

Date of Birth: _____ SSN: _____ Gender: ❑ Male ❑ Female

Section 2: *Billing Information*

Type: ❑ Medicare ❑ Medicaid ❑ 3rd Party ❑ Self Pay

Carrier: _____

Member ID: _____

Group ID: _____

Section 3: *Consent/Release*

I, the undesigned, understand and grant permission to Mako Medical Laboratories, LLC to bill my insurance for toxicology laboratory services provided. I understand that services rendered may not be covered by my insurance. I further understand that I may be responsible for co-pays, deductibles, and any amount not covered by my insurer. By signing below, I accknowledge that payment may be made on my behalf to Mako Medical Laboratories, LLC. I hereby allow the release of any personal or medical information that may be needed to process claims related to services rendered by Mako Medical Laboratories, LLC and its affiliates.

I confirm that the above information is true and correct to the best of my knowledge. I understand that it is my responsibility to provide updated information when available. Unless provided new or updated information, the above will remain in effect for one (1) year after the below date.

Signature: _____

Date: _____

(Please retain this document on file at the patient's clinic or practice.)

Authorization for Release of Protected Health Information

PLEASE PRINT CLEARLY AND COMPLETELY

Patient Full Legal Name: _____ Date of Birth: _____

Street Address: _____ Social Security #: _____

City, State, Zip: _____ Best Contact #: (_____)_____

Email Address: _____ May we leave a message at this number: ☐ Yes ☐ No

RELEASE INFORMATION FROM:	**RELEASE INFORMATION TO:**
_____	Lowcountry Wellness Center
Name of Facility or Practice	Name of Facility, Person or Company
_____	Charleston, SC 29407
City, State, Zip	City, State, Zip
_____	843-793-1353 214-556-6951
Phone Number Fax Number	Phone Number Fax Number

PURPOSE OF RELEASE (check reason): ☐ Request of Individual/Personal Use ☑ Continued Patient Care ☐ Insurance

☐ Legal Purpose (including discussions & proceedings) ☐ Other_____

DATES OF TREATMENT OR DATE RANGE OF RECORDS TO BE RELEASED: From _____ **To** _____

HOSPITAL INFORMATION TO BE RELEASED (check all that apply):

☐ Hospital Summary (may include H&P, discharge summary, operative notes, consults, diagnostic test results, medication list and allergies)
☐ Discharge Summary
☐ History and Physical
☐ Consultation Reports
☐ Entire Record (not including psychotherapy notes)
☐ Cardiac Reports
☐ Emergency Record
☐ Operative Reports
☐ Laboratory Reports
☐ Radiology/X-Ray Reports
☐ Pathology Reports
☐ Other: _____

Fees May Apply. Requests for more than ten pages will be processed by our copy service who will contact you about charges that may apply pursuant to SC Code Section 44-115-80.

FORMAT (check one)	**DELIVERY METHOD (check one)**
☑ Paper copy	☑ Reg.US Mail
☐ Email Address noted above, where permitted	☐ Pick-up
☐ Jump Drive (where available)	☑ Fax, where permitted
☐ CD (where available)	☐ Secure Email, where permitted
☐ Other: _____	☐ Other: _____

PATIENT'S RIGHTS – I understand that:

- I can cancel this permission at any time. I must cancel in writing and send or deliver the cancellation to the releasing facility or practice named above. Any cancellation will apply only to information not yet released by the facility or practice.
- This is a full release including information related to behavioral/mental health, drug and alcohol abuse treatment (in compliance with 42 CFR Part 2), genetics, HIV/AIDS, and other sexually transmitted diseases.
- Once my health information is released, the recipient may disclose or share my information with others and my information may no longer be protected by federal and state privacy protections.
- Refusing to sign this form will not prevent my ability to get treatment, payment, enrollment in a health plan, or eligibility for benefits.
- RSFH will not share or use my health information without my permission other than by ways listed in RSFH's Notice of Privacy Practices or as required by law. The Notice of Privacy Practices is available at www.rsfh.com.
- A fee may be charged for providing the protected health information.
- I have a right to receive a copy of this form upon request.

This permission expires one year after the date of my signature unless an earlier date or event is written here: _____

Print Name: _____**Patient Signature:** _____ **Date:**____/_____/____

NOTE: If the patient lacks legal capacity or is unable to sign, an authorized personal representative may sign this form. Check relationship/authority if signature is not that of the patient (written proof may be requested):

☐ Healthcare Agent/POA ☐ Guardian ☐ Executor/Administrator/Attorney in Fact ☐ Spouse
☐ Parent ☐ Adult Child ☐ Affidavit/ Next of Kin ☐ Other: _____

RETURN COMPLETED FORM IN PERSON, BY MAIL OR BY FAX WITH A COPY OF YOUR PHOTO I.D.

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