## 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.<br>• 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.<br>• 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.<br>• 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.<br>• 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.<br>• 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.<br>• 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.<br>• 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/.**<br>• 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<br>• Share information in a disaster relief situation<br>• Include your information in a hospital directory<br>*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<br>• Sale of your information<br>• 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:<br>  • Preventing disease<br>  • Helping with product recalls<br>  • Reporting adverse reactions to medications<br>  • Reporting suspected abuse, neglect, or domestic violence<br>  • 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:<br>  • For workers' compensation claims<br>  • For law enforcement purposes or with a law enforcement official<br>  • With health oversight agencies for activities authorized by law<br>  • 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: 08/1/2020*

**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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# PATIENT AGREEMENT

**Patient Information:**

Name: _____ Date of Birth: _____/_____/_____

Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____ Home Phone: (  ) _____

Cell Phone: (  ) _____ Email: _____

Employed By:_____Client Occupation: _____

Business Address: _____ Business Phone: (  ) _____

**Section A. Amenities Provided by Lowcountry Wellness Center, LLC:**

Lowcountry Wellness Center, LLC ("LWC") enables its Patients to have highly personalized, rapid access to a healthcare. LWC has agreed to provide you with the following amenities:

1. Patient shall receive medical services that are consistent with the training and experience of the Practitioner.

2. An annual "Wellness Examination and Evaluation" performed by a Practitioner: This shall include a health risk assessment, an EKG when appropriate, a psychosocial screening, and a customized wellness plan that consists of exercise and dietary guidelines.

3. Practitioner Access: Patient shall have direct phone and SMS message access to the Practitioner outside of business hours when reasonably necessary. Patients shall also be able to communicate with the Practitioner via text, email, telephone, and video chat when scheduled in advance.

4. Substitute Practitioners: During the Practitioner's absence, a substitute licensed Practitioner will be available to provide medical services. LWC will provide instructions on how to contact the Substitute Practitioner. While the Substitute Practitioner will have the same availability as our usual Practitioner, contact may be made through an answering service rather than direct access.

**5.** E-mail: Patient shall be provided with the Practitioner's email address for non-urgent communications. A Practitioner or appropriate staff member *shall make a reasonable effort to respond within twenty-four (24) hours*. **NOTE: Email shall not be used to access care in the event of an emergency. If an emergency arises, Patient should contact 911 or proceed to the emergency room.**

6. Same or next day appointments: LWC will make every reasonable effort to triage requests for same or next day appointments. Emergency and urgent appointments will be determined by appropriately trained staff and shown priority as spots are limited to time between regularly scheduled appointments.

7. On-time appointments: Patients shall be seen at the scheduled appointment time. If the Practitioner foresees a minimal wait time, the Patient shall be notified. If the Patient is fifteen (15) or more minutes late, Patient may be asked to reschedule.

8. Location: Patient may request the appointment to occur in the office or via telephone. Practitioner shall comply with Patient's request at his/her discretion.

**9.** Specialists: LWC shall assist in scheduling necessary appointments with specialists, diagnostic, or therapeutic procedures for Patient to the best of their ability. **NOTE: Fees paid under this Agreement do not include or cover specialists' fees or fees due to any medical professional that is not part of the Lowcountry Wellness Center, LLC.**

Please note that LWC may add, delete, or change the available amenities in its sole discretion. Any changes would be effective thirty (30) days after LWC provides written notice of said changes. If Patient is not satisfied with any such changes, Patient may terminate this Agreement by providing written notice to LWC within thirty (30) days of LWC's written notice of the change.

**Section B. Fees**

Patients must pay a membership fee to Lowcountry Wellness Center - enrollment begins at time of sign up. Memberships may be paid monthly, quarterly, bi-annually, or annually.

$50.00/month for Patients ages (12-39)

**OR** for Patients under corporate enrollment

$75.00/month for Patients ages 40-64

$100.00/month for Patients ages 65+

*This fee does not include medications or laboratory services or procedures, which are provided at a reasonable cost.*

If this Agreement is held to be invalid for any reason and if LWC is required to refund any portion or all the fees paid by Patient, Patient agrees to pay LWC an amount equal to the reasonable value of the services rendered to Patient during the period of time for which the refunded fees were paid.

By signing below, Patient agrees to make the payments identified in this section.

**Section C. Insurance or Other Medical Coverage**

1. Patient acknowledges that this Agreement is ***not an insurance plan***, nor is it a substitute for an insurance plan. LWC makes no representation that any fees paid under this Agreement are covered by your health insurance or other third-party payment plan. Patient retains full and complete responsibility for any such determination.

2. This Agreement and payments made under this Agreement will not cover any medical services, including but not limited to specialists' services and hospital services, that are not provided by Lowcountry Wellness Center, LLC or its Practitioners. Patient acknowledges that LWC recommends that Patient should obtain or continue to carry health insurance policies or plans that will cover medical services provided outside of Lowcountry Wellness Center, LLC.

3. By acknowledging this Terms of Service, you acknowledge that Dr. Penni Vachon, APRN is opted out of Medicare. This means Medicare cannot be used to cover the monthly fee associated with a Lowcountry Wellness Center

monthly membership ($100.00/month for those ages 65+). All Medicare patients can continue to use Medicare to cover services provided outside of Lowcountry Wellness Center including pharmacy services, laboratory services, imaging services and specialty care services.

**Section D. Term and Termination**

1. This Agreement will be effective as of the date of Patient's online enrollment (the "Effective Date"). LWC will accept automatic draft payments for the monthly fee. If Patient fails to pay the monthly fee by the due date, and the Patient has not established a relationship with a Lowcountry Wellness Center Practitioner, then this Agreement will terminate. A Patient-Practitioner relationship is established on the first visit or if telemedicine care is provided at the request of the Patient prior to the first visit.

2. Either Patient or LWC may terminate this Agreement and Patient's relationship with LWC at any time by providing 30 days written notice.

3. If any payment is overdue by 30 days or more, the overdue party's status will be changed from active to inactive. The membership status will be maintained at this point. However, no services will be provided to the inactive party until payment to Lowcountry Wellness Center is made in full. This will include access to our in-office services, labs, office visits, referrals, etc.

4. If full payment is not received prior to 60 days (2 months of consecutive non-payment), it will be assumed the Patient has chosen to self-terminate and the Patient's account will be archived and the associated membership with Lowcountry Wellness Center will be cancelled.

5. If a Patient wishes to re-join LWC after having been archived and their membership removed, the Patient will need to re-enroll. The re-enrollment process will include payment of any past due balance and a re-enrollment fee equal to 3 months of membership. Applications for re-enrollment will be accepted at the discretion of LWC staff.

Upon termination of this Agreement for any reason, LWC shall continue to provide **emergency medical services only** for thirty days while Patient transitions to a new Practitioner. Patient shall be financially responsible for the 30 days of emergency services. LWC shall provide reasonable assistance for this transition, including providing Patient's medical records.

**Section E. Confidentiality**

LWC agrees to keep Patient's information and medical records confidential and will not use or disclose it to others without permission during the term of this Agreement, except as required by this Agreement, or as required or permitted by law. Patient authorizes LWC to share his/her confidential Patient information with treating Practitioners, hospitals, health care facilities and licensed health care practitioners as necessary to provide medical services.

**Section F. Communication**

**Email:**

By providing an email address above, Patient authorizes communication with LWC via email regarding Patient's health information. Patient acknowledges the following:

1. Email is not necessarily a secure medium and there is the potential an unauthorized person/entity may gain access to the information.

2. LWC does not guarantee the confidentiality of electronic communications.

3. In the discretion of LWC, email communications may be made part of Patient's medical record.

4. **If Patient does not receive a response to an email message within one (1) day, Patient agrees to use another means of communication to contact LWC or the Practitioner**.

Neither LWC nor the Practitioner shall be liable to Patient for any loss, cost, injury, or expense caused by, or resulting from, a delay in responding to Patient as a result of technical failures, including but not limited to power outages, internet outages, incorrect addresses, misuse, and/or malfunctioning hardware and/or software.

**Text and Media Messages:**

By Providing a mobile phone number for SMS, MMS, and/or iMessages, Patient authorizes communication with LWC via short message service (text message), Multimedia Message Service (photo, video, etc.. content text message) or iMessage (ISO and Mac device messages) regarding Patient's health information. Patient acknowledges the following:

1. Text and media messages are not necessarily a secure medium and there is a potential for unauthorized person/ entity may gain access to the information.

2. LWC does not guarantee the confidentially of electronic communications.

3. In the discretion of LWC, Messages may be made a part of Patient's medical record.

4. **If Patient does not receive a response to message within one (1) day, Patient agrees to use another means of communication to contact LWC or the Practitioner**.

Neither LWC nor the Practitioner shall be liable to Patient for any loss, cost, injury, or expense caused by, or resulting from, a delay in responding to Patient as a result of technical failures, including but not limited to loss or damage of message device, change of number, incorrect number, lack of reception, misuse, power outages, internet outages, and/or malfunctioning hardware and/or software.

**Section G. Waiver of Breach**

The waiver by either party of a breach of any provision of this Agreement by the other party ("Defaulting Party") shall not operate or be construed as a waiver of any subsequent breach by such Defaulting Party.

**Section H. Notices**

Any notice or communication concerning this Agreement shall be in writing and shall be considered delivered when sent by United States first-class mail, postage prepaid, to the addresses provided in this Agreement. Either party may change its address by written notice to the other party.

**Section I. Assignment**

This Agreement shall not be assigned whether individually or by operation of law by either party without prior written consent, except that LWC may assign this Agreement to its successor without your consent in the event of any merger, consolidation, reorganization or acquisition of LWC.

**Section J. Governing Law**

This Agreement shall be governed in accordance with the laws of the State of South Carolina. Any litigation related to this Agreement or related to the services provided via this Agreement shall be brought exclusively in the state or federal courts located in Charleston County, South Carolina and in no other venue. The parties irrevocably consent to the jurisdiction of the courts in Charleston County, South Carolina, whether federal or state, for all such disputes.

**Section K. Severability**

Should any part(s) of this Agreement be determined to be invalid, unlawful or unenforceable, the validity of any other part(s) of this Agreement shall not be affected.

**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.)*