Family MedCenters Of Aiken

216 Edgefield Ave NW
Aiken, SC 29801-3910
(803) 648-4224

PATIENT INFORMATION

NAME (Last, First Middle)	MRN	SSN#	BIRTHDATE	LANGUAGE	SEX

LOCAL ADDRESS	CITY, STATE ZIP	REFERRING PHYSICIAN	SECONDARY/BILLING ADDRESS	ETHNICITY

HOME PHONE	DAY PHONE	EMAIL ADDRESS	PRIMARY CARE PROVIDER	CITY, STATE ZIP	RACE

MARITAL STATUS	STUDENT STATUS	SMOKER (Y/N)?	VETERAN (Y/N)?	EMERGENCY CONTACT NAME	CONTACT PHONE	HOME PHONE
	☐ Full-Time ☐ Part-Time					

PRIMARY EMPLOYER	SECONDARY EMPLOYER (if Applicable)
ADDRESS	ADDRESS
CITY, STATE ZIP	CITY, STATE ZIP
WORK PHONE	WORK PHONE

RESPONSIBLE PARTY INFORMATION (if Different than above)

NAME (Last, First Middle)	SSN#	BIRTHDATE	LANGUAGE	SEX

LOCAL ADDRESS	CITY, STATE ZIP	SECONDARY/BILLING ADDRESS (if Applicable)

HOME PHONE	DAY PHONE	EMAIL ADDRESS	CITY, STATE ZIP

MARITAL STATUS	STUDENT STATUS	SMOKER (Y/N)?	VETERAN (Y/N)?	PRIMARY CARE PROVIDER	HOME PHONE
	☐ Full-time ☐ Part-time				

RELATIONSHIP TO PATIENT	

PRIMARY INSURANCE

NAME OF INSURANCE COMPANY		POLICY#	
NAME OF INSURED		GROUP#	
ADDRESS OF INSURANCE COMPANY		COPAY AMT	$
CITY, STATE ZIP	PHONE	DEDUCTIBLE	$
RELATIONSHIP TO PATIENT		EFFECTIVE DATE	EXPIRATION DATE

SECONDARY INSURANCE (if Applicable)

NAME OF INSURANCE COMPANY		POLICY#	
NAME OF INSURED		GROUP#	
ADDRESS OF INSURANCE COMPANY		COPAY AMT	$
CITY, STATE ZIP	PHONE	DEDUCTIBLE	$
RELATIONSHIP TO PATIENT		EFFECTIVE DATE	EXPIRATION DATE

I hereby authorize that payment due me in my pending insurance claim be made directly to _____.

SIGNATURE OF PATIENT/GUARDIAN

DATE

Patient Name: _____ Date of Birth: _____

FINANCIAL POLICY

Welcome to Family Medcenters! Our entire staff appreciates your selection of our office to serve your medical needs. Our goal, in this practice is to provide quality medical care for you and your family.

THANK YOU FOR CHOOSING FAMILY MEDCENTERS!

This information has been prepared to inform you of our payment policy. If you are unable to meet this criteria, please inform our front office staff immediately, so that some other arrangement may be made:

1. All balances are due and payable at the time of service. We accept cash, personal checks, Mastercard, Visa, Discover and American Express credit cards. We do not accept unprinted checks, third party checks, or post dated checks.

2. If we are already contracted to file your insurance, we will do so. However, we do not accept this insurance as full payment! You are also expected to pay your appropriate copay and/or deductible at the time of service. You are also responsible for any amount unpaid or noncovered after your insurance has paid us all that it is going to pay. We will mail you a bill indicating the amount that you must then promptly pay us.

3. We are also providers for Medicare, but again we do not accept it as payment in full. You must be prepared to pay your portion of the deductible and / or your copay on the date of service.

4. If you have Medicaid, you must present the card at the time of service in order for us to verify eligibility. You must be prepared to pay your copay as well for each date of service.

5. If your employer, or a prospective employer, has initiated your visit to our facility, financial arrangements have more than likely been arranged prior to your visit. They will be billed accordingly for the services rendered.

6. If you are here for a workers' compensation visit we will file the claim with your employer or their workers' comp carrier. However, please be aware that if the claim is denied, you will be responsibile for any balance that was denied.

Please sign below to indicate that you have read and understand this agreement.

If you have any questions, please feel free to speak with our Front Office Staff or our Insurance and Billing Staff.

Again, THANK YOU FOR CHOOSING FAMILY MEDCENTERS!

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance on my account for any services rendered.

_____ _____

Date Patient Signature - If minor, Parent Signature

216 Edgefield Avenue NW
Aiken SC 29801
803-648-4224
www.familymedcenters.com

Family MedCenter of Aiken

Henry Tam, MD

Compound Authorization for Release of Information

Name of Patient_____ **Date of Birth**_____

Family MedCenter is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patients instructions.

Entity to Receive Information. Check each person/entity that you approve to receive information.	**Description of information to be released.** Check each that can be given to person/entity on the left in the same section.
❒ONLY RELEASE INFORMATION TO ME PERSONALLY	
❒Voice Mail_____ ❒Answering Machine_____	❒Results of lab tests / x-rays ❒Other_____
❒Give information to employer ❒Give information to school	❒Appointment / Absentee information ❒Diagnosis for Date of Absences
❒Spouse_____ ❒Significant Other_____	❒Family billing information ❒Financial ❒Medical as follows:_____
❒Parent (Provide Name)	❒Family billing information ❒Financial ❒Medical as follows:_____
❒Other (Provide Name)	❒Financial ❒Medical as follows:_____
❒Support Group (Provide Name)	❒Demographic information ❒Other_____

Rights of the Patient

* I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending a written notification to the office address above.
* I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward
* 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 refuse to sign this authorization and that my treatment will not be conditioned on signing.

This authorization shall be in effect until revoked by the patient.

_____ Date_____

Signature of Patient, Parent or Personal Representative

Description of Personal Representative's Authority (attach necessary documentation)

Family MedCenter of Aiken

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Aiken SC 29801
803-648-4224

Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name and Address: _____

_____

_____

I have received a copy of the notice of Privacy Practices for the above named practice.

_____ _____

Signature Date

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- ☐ An emergency existed and a signature was not possible at the time.
- ☐ The individual refused to sign
- ☐ A copy was mailed with a request for a signature by return mail
- ☐ Unable to communicate with the patient for the following reason:

  _____
- ☐ Other: _____

  _____

Prepared by _____

Signature _____

Date _____

Notice Of Privacy Practices for Family MedCenter of Aiken

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.

Healthcare 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.
This practice may contact you for our own fundraising activities. If you do not want to receive fundraising communication, you may opt-out at any time. If you opt-out you will receive no further fundraising communications.

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
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 will 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 on/or before September 23, 2013.

Patient Copy for Your Records