Patient Information

Patient Last Name	First Name	Middle Initial	Date of Birth	Sex

Mailing Address	City	State	Zip Code

Primary Telephone	Other Telephone	Activate Patient Portal?	Email Address
		☐ Yes ☐ No	

Primary Language	Do you need an Interpreter?	Ethnicity	Hearing Impaired?	Vision Impaired?
	☐ Yes ☐ No		☐ Yes ☐ No	☐ Yes ☐ No

Employer Name	Employer Telephone

Employer Address	Employer City	Employer State	Employer Zip Code

Primary Care Physician	Referring Physician

Emergency Contact Information

Last Name	First Name	Relationship to Patient	Primary Telephone	Legal Guardian

Responsible Party if other than Patient

Last Name	First Name	Relationship to Patient	Primary Telephone

Street Address	City	State	Zip Code

Medical Insurance Policy Holder

Primary Insurance Company	Policy Holder Last Name	Policy Holder First Name	Relationship to Patient

Subscriber ID	Group Number	Date of Birth

Secondary Insurance Company	Policy Holder Last Name	Policy Holder First Name	Relationship to Patient

Subscriber ID	Group Number	Date of Birth

Assignment of Benefits / Consent for Treatment

I do hereby assign all medical benefits to which I am entitled, including all government and private insurance plans to this office. This assignment will remain in effect until revoked by me in writing. I acknowledge receipt of the Financial Policy and I understand that I am responsible for all charges not paid by insurance. I authorize this practice to release all information necessary to secure payment. I hereby voluntarily consent to treatment at this office and authorize such treatments, examinations, medications, and diagnostic procedures (including, but not limited to the use of lab and radiographic studies) as ordered by attending providers. I hereby voluntarily consent to the taking of photographic images for treatment purposes only (wound care progression, documentation of rashes, etc.) as ordered by the attending providers.

Signature of Patient / Legal Guardian	Date

Patient Information

Patient Last Name	First Name	Date of Birth

Reason for Visit	Allergies

Preferred Pharmacy	Pharmacy Telephone	Pharmacy Address

Please list your current medications:

1.	mg
2.	mg
3.	mg
4.	mg
5.	mg
6.	mg
7.	mg
8.	mg
9.	mg
10.	mg

Please list medications you have tried in the past for your autoimmune condition(s)

1.	mg
2.	mg
3.	mg
4.	mg

History of smoking and alcohol use:

Do you currently drink alcohol?	◯ Yes ◯ No
Did you used to drink alcohol?	◯ Yes ◯ No
Do you currently smoke tobacco?	◯ Yes ◯ No
Did you used to smoke tobacco?	◯ Yes ◯ No

Please list any diseases, illnesses, or surgeries you have now or have had previously:

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.

Please list the physicians who care for you now or have cared for you in the past:

1.
2.
3.
4.

Please indicate below the history of arthritis or rheumatic disease in your family:

	Mother	Father	Sibling(s)
Rheumatoid Arthritis	☐	☐	☐
Gout	☐	☐	☐
Psoriasis	☐	☐	☐
Lupus	☐	☐	☐
Other	☐	☐	☐

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Contact the Privacy Officer at 855-472-9400 or 843-793-6980 with any questions.

EFFECTIVE: NOVEMBER 13, 2019

We are committed to protect the privacy of your personal health information (PHI). This Notice of Privacy Practices (Notice) describes how we may use within our practice or network and disclose (share outside of our practice or network) your PHI to carry out treatment, payment or health care operations. We may also share your information for other purposes that are permitted or required by law. This Notice also describes your rights to access and control your PHI.

We are required by law to maintain the privacy of your PHI. You will be notified of any breach of unsecured PHI. We will follow the terms outlined in this Notice. We may change our Notice, at any time. Any changes will apply to all PHI. Upon your request, we will provide you with any revised Notice by:

- Posting the new Notice in our office.
- Providing a copy of the new Notice in our office or by mail, upon request.
- Posting the revised Notice on our website**: lowcountryrheumatology.com**

Uses and Disclosures of Your PHI

The law permits or requires us to use or disclose your PHI for various reasons, which we explain in this Notice. We have included some examples, but we have not listed every permissible use or disclosure. When using or disclosing PHI or requesting your PHI from another source, we will make reasonable efforts to limit our use, disclosure, or request about your PHI to the minimum we need to accomplish our intended purpose.

Uses and Disclosures for Treatment, Payment or Health Care Operations

- **Treatment:** We may use or disclose your PHI and share it with other professionals who are treating you, including doctors, nurses, technicians, medical students, or hospital personnel involved in your care. For example, we might disclose information about your overall health condition with physicians who are treating you for a specific injury or condition.
- **Payment:** We may use and disclose your PHI to bill and get payment from health plans or others. For example, we share your PHI with your health insurance plan so it will pay for the services you receive.
- **Health Care Operations:** We may use and disclose your PHI to run our practice and improve your care. For example, we may use your PHI to manage the services you receive or to monitor the quality of our health care services.

Other Uses and Disclosures of Your PHI

We may share your information in other ways, usually for public health or research purposes or to contribute to the public good. For example, these other uses and disclosures may involve:

- **Our Business Associates:** We may use and disclose your PHI to our business associates that perform services on our behalf, such as auditing, legal, or transcription. The law requires our business associates and their subcontractors to protect your PHI in the same way we do. We also contractually require these parties to use and disclose your PHI only as permitted and to appropriately safeguard your PHI.
- **Health Information Exchanges:** We participate in health information exchanges (HIEs), which support electronic information sharing among members for treatment, payment, and health care operations purposes. Individuals may opt-out of HIEs. We will use reasonable efforts to limit the sharing of PHI in these electronic sharing activities for individuals who have opted out. If you would like to opt out, please contact our Privacy Officer.
- **Legal Compliance:** For example, we will share your PHI if the Department of Health and Human Services requires it when investigating our compliance with privacy laws.

- **Public Health and Safety Activities:** For example, we may share your PHI to report injuries, births, and deaths; prevent disease; report adverse reactions to medications or medical device product defects; report suspected child neglect or abuse or domestic violence; or avert a serious threat to public health or safety.
- **Responding to Legal Actions:** For example, we may share your PHI to respond to a court or administrative order or subpoena; discovery request; or another lawful process.
- **Research:** For example, we may share your PHI for some types of health research that do not require your authorization, such as if an institutional review board (IRB) has waived the written authorization requirement [because the disclosure only involves minimal privacy risks].
- **Medical Examiners or Funeral Directors:** For example, we may share PHI with coroners, medical examiners, or funeral directors when an individual dies.
- **Organ or Tissue Donation:** For example, we may share your PHI to arrange an authorized organ or tissue donation from you or a transplant for you.
- **Workers' Compensation:** We may use and disclose your PHI for workers' compensation claims; health oversight activities by federal or state agencies; law enforcement purposes or with a law enforcement official; or specialized government functions, such as military and veterans' activities, national security and intelligence, presidential protective services or medical suitability.

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, please contact us and we will make reasonable efforts to follow your instructions. You have both the right and choice to tell us whether to:

- Share information such as your PHI, general condition or location, with friends or family members, or other persons involved in your care.
- Share information in a disaster relief situation, such as to a relief organization to assist with locating or notifying your family, close friends or others involved in your care.

We may share your information if we believe it is in your best interest, according to our best judgment, and:

- If you are unable to tell us your preference, for example, if you are unconscious.
- When needed to lessen a serious and imminent threat to health or safety.

Your Rights

You have certain rights related to your protected health information. All requests to exercise your rights must be made in writing.

Inspect and Obtain a Copy of your Protected Health Information: You may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. If requested, we will provide you a copy of your records in an electronic format. There are some exceptions to records which may be copied and the request may be denied. We may charge you a reasonable cost-based fee for a copy of the records.

Request Additional Restrictions: You have the right to ask us to limit what we use or share about your PHI. You can contact us and request us not to use or share certain PHI for treatment, payment, or operations or with certain persons involved in your care. For these requests:

- we are not required to agree;
- we may say "no" if it would affect your care; but
- we will not agree to disclose information to a health plan for purposes of payment or health care operations if the requested restriction concerns a health care item or service for which you or another person, other than the health plan, paid in full out-of-pocket, unless otherwise required by law.

You have the right to request for us to communicate in different ways or in different locations. We will agree to reasonable requests. We may also request alternative address or other method of contact such as mailing information to a post office box. We will not ask for an explanation from you about the request.

Make Amendments: You may ask us to correct or amend PHI that we maintain about you that you think is incorrect or inaccurate. For these requests:

- You must submit requests in writing, specify the inaccurate or incorrect PHI and provide a reason that supports your request.
- We will generally decide to grant or deny your request within 60 days. If we cannot act within 60 days, we will give you a reason for the delay in writing and include when you can expect us to complete our decision.
- We may deny your request for an amendment if you ask us to amend PHI that is not part of our record, that we did not create, that is not part of a designated record set, or that is accurate and complete.

Request an Accounting of Disclosures: This right applies to disclosures for purposes other than treatment, payment or healthcare operations. You may request them for the previous six years or a shorter time frame. If you request more than one list within a 12-month period, you may be charged a reasonable fee.

Additional Privacy Rights

You have the right to obtain a paper copy of this notice from us, upon request. We will provide you a copy of this Notice the first day we treat you at our facility. In an emergency we will give you this Notice as soon as possible. You have a right to receive notification of any breach of your protected health information.

Complaints

You have the right to complain if you feel we have violated your rights. We will not retaliate against you for filing a complaint. You may either file a complaint:

- directly with us by contacting the Privacy Officer. All complaints must be submitted in writing.
- with the Office for Civil Rights at the US Department of Health and Human Services (HHS). Send a letter to U.S. HHS at 200 Independence Ave., S.W., Washington, D.C. 20201; call 1-800-368-1019; or visit www.hhs.gov/ocr/privacy/hipaa/complaints/

ACKNOWLEDGMENT OF RECEIPT

"NOTICE OF PRIVACY PRACTICES"

I ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF THE "NOTICE OF PRIVACY PRACTICES" FOR PROTECTED HEALTH INFORMATION ON THE DATE SET FORTH BELOW.

Date of Receipt

Patient Date of Birth

Relationship to Patient

Print Patient Name

Print Name of Authorized Representative

Patient Signature

Signature of Authorized Personal Representative

FOR USE BY PRACTICE PERSONNEL ONLY

(COMPLETE ONLY IF PATIENT ACKNOWLEDGMENT IS NOT OBTAINED)

AN ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES WAS NOT RECEIVED BECAUSE:

- ☐ Patient refused to sign Acknowledgment
- ☐ Unable to gain signed Acknowledgment due to communication / language or another
- ☐ barrier Patient was unable to sign Acknowledgment due to emergency treatment situation
- ☐ Other (please indicate reason): _____

Staff Signature

This information is used to facilitate our communications with you as we strive to provide you with excellent service.

PATIENT INFORMATION (PLEASE PRINT CLEARLY)

Last Name | First Name | Middle Initial | Date of Birth (Month/Day/Year)

Street Address | Apt # / P.O. Box # (please include complete mailing address) | Medical Record # / SSN

City | State | Zip Code | Primary Contact Number

If we cannot reach you at the telephone number listed above, Low Country Rheumatology may contact you (including leaving messages) regarding appointments or normal lab results at the following number(s):

Business # | Cell Phone # | Other Phone #

I authorize Low Country Rheumatology to disclose Protected Health Information to the following persons:

☐ Spouse: _____ Name _____ Phone #

☐ Child(ren): _____ Name _____ Phone #

_____ Name _____ Phone #

☐ Other: _____ Name _____ Phone #

_____ Name _____ Phone #

INFORMATION TO BE DISCLOSED:

☐ All Medical Information ☐ Laboratory Results ☐ All Billing/Account Information

AUTHORIZATION STATEMENT:

I understand that Protected Health Information (PHI) used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer protected by Federal or State Law. I understand that I have the right to revoke this authorization at any time. I understand that in order to revoke this authorization, I must do so in writing and present my revocation to the Low Country Rheumatology location where I received care. I understand that the revocation will not apply to information that has already been used or disclosed in response to this authorization. I understand that Low Country Rheumatology cannot require me to sign this authorization as a condition of treatment unless the provision of health care by Low Country Rheumatology is solely for the purpose of creating PHI for disclosure to a third party legally authorized to receive such information. I understand that I will be given a copy of this authorization.

EXPIRATION DATE: THIS AUTHORIZATION IS VALID UNTIL WRITTEN NOTICE IS PROVIDED TO REVOKE THIS AUTHORIZATION.

Signature Date

(date authorization signed by Patient or Legal Guardian/Personal Representative)

Indicate Relationship to Patient

(required)

Print Patient Name or Name of Legal Guardian/Personal Representative

Signature of Patient or Name of Legal Guardian/Personal Representative

We thank you for choosing us as your healthcare provider. Our team of physicians and healthcare professionals are committed to fulfilling our mission to provide a continuum of medical services to our patients. To support this goal, we have created this financial policy to communicate important financial aspects about our practice. Please read this policy thoroughly before your visit and contact our Billing Office should you have questions or concerns. Our Billing Office is available Monday – Thursday from 8:00am – 5:00pm, and you may reach them by dialing 843-793-6980. Additionally, any uninsured, underinsured, and/or indigent patients who have limited or inadequate resources to pay for health care services rendered at any of our clinic locations may be eligible for financial assistance through payment options and our Financial Assistance Program.

Arriving for Your Visit

To provide exceptional care to every patient, we have adopted guidelines around late arrivals, cancellations, and patients who fail to show for their appointments. We ask that every new patient arrive 15 minutes before their scheduled appointment time. Should you arrive more than 15 minutes late to your appointment, you will have the option to reschedule your appointment or have your physician see you as a "work in" appointment that day as the schedule allows. If you do not arrive for your appointment or if you cancel within 24 hours of your appointment, a $25 charge may be applied to your account. We reserve the right to discharge patients who arrive late, cancel within of 24 hours of their visit, and/or no show for their appointments three times within a 12-month period.

Please note the charge for a no-show new patient appointment is $50, and must be paid before being rescheduled. Arriving 15 minutes past your scheduled appointment time may result in being charged the above mentioned fees.

Referrals and Prior Authorizations

It is your responsibility to obtain referrals for the services provided within our practice. However, we will obtain any of the required prior authorizations for treatments or services provided within our practice.

Insurance and Billing

We are pleased to bill your primary and secondary health care plans on your behalf. You are ultimately responsible for your co-pay and any co-insurance related to your deductible at check-in for your appointment, as well as any remaining balance after insurance payments. Ancillary services rendered in our clinic, like ultrasound, lab, and/or x-ray, will be billed to you after your visit. We accept most insurance policies, including Medicaid for patients. Please contact your insurance company to verify we are an in-network provider. As the owner of the insurance policy, you are solely responsible for coverage policies under the plan and the accuracy of information on file.

Insurance Errors

If you believe your insurance company denied or processed a claim in error, please call us immediately. If your insurance company requests additional information from you, it is important to comply with their requests in a timely manner. If insurance does not pay a claim within 45 days of submission, the outstanding balance is billed to the patient and becomes the patient's responsibility. Should you pay more than what you are responsible, the overpayment will be applied as a credit on the account. You may decide to use the credit at your next visit or opt to receive a refund check.

Paying Your Bill

For your convenience, we accept multiple forms of payment, including personal check, money order, credit card, and cash. Payment is accepted by phone, online, in person, and by mail. If we utilize lab processing through a third-party lab, they will bill you directly. Please contact Quest Diagnostics directly to discuss your bill at 866-MYQUEST (866-697-8378).

Credit Cards on File

Should you carry a balance after 30 days or are eligible for a payment plan, you must keep an active HSA and or credit card on file. We do not have access to patients' credit/debit/HSA/bank information. Private financial information is stored and encrypted by a certified company that is compliant with all federal privacy laws, as well as the Payment Card Industry Data Security Standards (PCI DSS).

Ability to Pay

Account balances should be paid in full by the statement due date. If you have circumstances that limit your ability to pay on your account balance and have exhausted other resources, please contact a member of the Billing Office to begin the Financial Assistance Program determination pro-cess. Holds may be placed on accounts without payment arrangements and future appointments may not be scheduled until past balances are fulfilled. Please note that specific financial and other pertinent information may be necessary to support a patient's eligibility for assistance. Failed attempts to contact patients about their unpaid balances to establish payment arrangements may lead to collections and/or discharge from the practice.

Accounts in Default

We will attempt to bill and collect from patients who are responsible for all or part of the cost of services provided by our providers. After 90 days, if you have not made a payment on a bill or established a payment plan, we may initiate pre-collections by sending the patient a pre-collections notice. If we fail to collect or arrange payment from the patient, the patient may receive a final notice to pay. If we decide it is unreasonable to try to collect balances, a certified letter discharging you from our practice will be sent, and the account referred to a collections agency.

Signature of Patient / Legal Guardian	Date

To eliminate paperwork and unnecessary phone calls, your physician will provide you enough medication to last until your next follow-up appointment. It should be unusual for you to need medication outside of your scheduled appointment, but refill requests are fulfilled with the following criteria in mind:

- ☐ Prescription refill requests are not accepted from pharmacies.
- ☐ To submit a prescription refill request, please by call us our office and press the corresponding number to reach your provider's care team. Please leave a detailed message with your full name, date of birth, and medication information; please note that all requests will be handled within 24 hours.
- ☐ Our practice will handle all refill requests submitted after hours, during weekends, and holidays the next business day except in an urgent situation.
- ☐ Please call your pharmacy directly to verify your prescription is ready for pick-up.
- ☐ We will send your refill electronically to the pharmacy documented in your medical record unless you request otherwise. We cannot call in any controlled medications. All patients must pick-up their controlled medication prescriptions in person. You may need to travel to the clinic location where your provider is located that day because written prescriptions require their signature.
- ☐ Any requested medication must have been previously ordered by an Articularis Rheumatology Specialists provider and you must have visited him/her within the last year.
- ☐ Our practice will prescribe or refill only enough of your medication to last until your next appointment with your provider.
- ☐ Refills of DMARDS medications may require bloodwork prior to fulfill the refill request.

Signature of Patient / Legal Guardian	Date

Medical Records Release

Patient Information *(please print clearly)*:

Last Name	*First Name*	*Middle Initial*	*Date of Birth (Month/Day/Year)*
Street Address	*Apt #/P.O. Box # (Please include complete mailing address)*		*Medical Record Number/SSN*
City	*State*	*Zip Code*	*Primary Contact Number*

I authorize Low Country Rheumatology to disclose the above-named individual's health information to:

☐ Another Facility:

_____
Name

_____
Street Address

_____
City *State* *Zip Code*

☐ I would like to pick up my records in person.

☐ I authorize _____ to pick up my medical records in person.
(Name of person authorized to receive the record)

The information to be disclosed:

☐ All Billing Records

☐ Complete Medical Record

OR

☐ Partial Medical Record *(please specify records below)*

Information	Dates
☐ Office Notes	_____
☐ Lab Results	_____
☐ X-Rays	_____
☐ Other	_____

The purpose of the disclosure:

☐ My personal records ☐ Disability

☐ Attorney ☐ Other _____

I understand that federal and state laws allow a fee to be charged for the copying of patient records and I will be responsible for the payment of such fees. The fee is $0.65 per page for the first 30 pages and $0.50 for each page after 30.

I authorize Low Country Rheumatology to obtain the above-named individual's health information on their behalf from:

_____

Name

_____

Street Address

_____

City *State* *Zip Code*

Information to be obtained*:

☐ Referral ☐ Clinical notes ☐ Recent labs and imaging reports ☐ Demographics

☐ All of the Above ☐ Other: _____

*Please fax information above to our Medical Records department at (843) 764-2726

If you have questions, please call (843) 572-4840.

Expiration of Authorization:

Unless I request in writing otherwise, this authorization will expire on _____. If I do not specify an expiration date or (insert date or event) event, this authorization will expire ninety (90) days from the date on which it was signed.

Right to Revoke Authorization:

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present written revocation to Articularis Rheumatology Specialists. I understand that the revocation will not apply to any health information that has already been released in response to this authorization.

Refusal to Authorize Use and/or Disclosure:

I understand that authorizing the use or disclosure of the information above is voluntary. I need not sign this form to ensure healthcare treatment

Re-Disclosure

I understand that if my health information is disclosed to a party other than a healthcare provider, health plan, or healthcare clearinghouse subject to the federal privacy regulations, my health information disclosed pursuant to this authorization may no longer be protected by the federal privacy regulations.

Release and Waiver

If the health information that I have requested Low Country Rheumatology to disclose contains any privileged psychiatric or psychological information related to the treatment of physical and/or mental illness, chemical dependency or alcohol abuse, or testing or treatment of any communicable or infectious disease such as acquired immunodeficiency syndrome (AIDS), Immunodeficiency Syndrome Related Complex (ARC), human immunodeficiency virus (HIV), venereal disease, tuberculosis, or hepatitis, I hereby waive any privilege concerning such information for the purpose(s) of releasing it to the party or parties authorized above. I also release Articularis Healthcare from any and all liabilities, damages, and claims which might arise from the release of the health information authorized by me above.

_____ _____

Signature of Patient or Patient's Legal Representative ***Month/Day/Year***

_____

Description of Authority to Act for Patient

NOTE: A COPY OF THIS COMPLETED, SIGNED, AND DATED FORM MUST BE PROVIDED TO THE PATIENT AND/OR THE PATIENT'S REPRESENTATIVE, AND A COPY MUST BE PLACED IN THE PATIENT'S MEDICAL RECORD