Welcome to Columbia Eye Surgery Center

Thank you for choosing Columbia Eye Surgery Center. Ophthalmic surgery is our area of expertise. We are the largest and most successful ophthalmic surgery center in the state, and patients find that their surgery can be performed in an outpatient setting that is convenient, comfortable, and economical. We want your experience at Columbia Eye Surgery Center to reflect our commitment to your care, comfort, and dignity. Our promise is to provide you and your family with exceptional care.

Pre-Registration
The Business Office will call you 1-2 weeks prior to your surgery date to discuss your financial obligations. **Payment in full is expected one week prior to surgery.**

Before Your Surgery
If at any time before your surgery you become ill or develop any new health problems, please call your surgeon at his/her office immediately. Changes in your health may impact your surgeon's decision to perform surgery.

****Please bring your blood pressure and diabetic medication(s) with you in their original containers to the surgery center. Be sure to take blood pressure and heart medications the morning of surgery with only a small sip of water.**

**Do not eat or drink anything (8) eight hours prior to your scheduled surgery time.

Anesthesia or sedation will not be given to any patient who has had anything to eat or drink within that prior (8) eight-hour time.

Complete the Universal Medication Form, the Medical History form, and the Ownership Form and bring them with you on your day of surgery.

**Someone must remain at the facility the entire time you are here. Your surgery will not be performed without someone present.

Visiting children under the age of 16 will not be permitted in patient care areas.

Patients who have a **Power of Attorney** (POA) must provide their (POA) documents upon admission.

Do not wear any make-up, contact lenses, nail polish, jewelry, cologne, perfume or perfumed products, or hair grooming products to the surgery center. You may shower and shampoo your hair the night before or the morning of surgery. You may brush your teeth.

What to Expect When You Arrive
Your blood pressure, temperature and pulse will be recorded along with a review of your medical history. Some procedures require eye drops to be administered. An I.V. will also be started.
Once these preparations have been completed, there will be some waiting time.

Patient Confidentiality
We abide by all HIPAA laws and will protect your privacy. We will only give information regarding your surgery to a person designated by you while you are here for your procedure.

When You Leave
After your surgery, you will remain in the recovery area approximately 15 to 30 minutes before you are discharged home. We will escort you to your vehicle by wheelchair.

Following surgery, you will not be able to operate a motor vehicle. You must have a family member or friend drive you to and from the surgery center. You will be given a copy of your discharge instructions.

Our Commitment to You
The physicians and staff of Columbia Eye Surgery Center are dedicated to providing you with the highest quality, state-of-the-art outpatient surgical care in a friendly, caring environment.

Our goal is to make you as comfortable as possible before, during, and after your surgery.

Columbia Eye Surgery Center (803) 254-7732

BRING YOUR DRIVERS LICENSE AND CURRENT INSURANCE CARD(S) WITH YOU THE MORNING OF SURGERY ALONG WITH THE FOLLOWING COMPLETED FORMS:

1) **PATIENT MEDICAL HISTORY** (Page 3)
2) **OWNERSHIP FORM** (Page 4)
3) **UNIVERSAL MEDICATION FORM** (Page 5)

You will be expected to pay any deductible or co-payment in full one week prior to your surgery.

Please report to:

Columbia Eye Surgery Center
1920 Pickens Street
Columbia, SC 29201
803-254-7732

Our hours of operation are from 6:30am to 4:00 pm. We do not open the doors before 6:30am.

The Surgery Center entrance is the single glass door to the left of the main entrance of the building.

Directions:

From I-26, proceed into downtown Columbia via Elmwood Avenue.
Turn right onto Bull Street and get immediately in your left lane.
Turn left at Calhoun Street.
We are located at the corner of Pickens Street and Calhoun Street

If you have questions, please call us at (803) 254-7732.

If you have questions regarding medications, eye drops, time of surgery or time to arrive, your physician prefers you contact his or her office prior to your appointment to have these questions answered.

Patient Information

Name:_____ DOB:____/____/____ Social Security #:_____/___/_____

Phone Number: (___)_-_____Cell Number: (_____)_____-_____Email Address:_____@_____

Home Address: _____

Emergency Contact Information

1. Name:_____Phone: (_)_____-_____ Relationship: _____

2. Name:_____Phone: (_)_____-_____ Relationship: _____

Primary Care Doctor:_____ Phone Number: (___)_____-_____

Pharmacy:_____Address:_____Phone Number: (___)_____-_____

List all **Allergies** (describe reaction to each): _____

_____

_____

_____ _____

Patient/Responsible Party/Significant Other Signature Date/Time

Responsible person (over 18) with you today who will be staying at the center during your procedure and who will be driving you home.

Not needed for laser procedures.

_____ _____ _____

Responsible Person Name Telephone Number Relationship

Columbia Eye Surgery Center

Patient Label

PATIENT MEDICAL HISTORY

Do you have or have you ever had…	Yes	No	Do you or have you??	Yes	No
Heart disease/Chest Pain/MI/High Cholesterol			Have trouble walking 1 block		
Ankle Swelling			Ever use oxygen		
Congestive Heart Failure			Have any physical restrictions- WC, cane, etc		
Pacemaker/Irregular Heart Rate/ AICD			Have dentures/capped/loose teeth		
High Blood Pressure			Wear contact lenses/glasses/hearing aids		
Valvular Heart Disease/Emphysema			Any objection to receiving blood / blood products		
Asthma/Wheezing/COPD/Sleep Apnea			Have Mental illness/Limitation in intellectual understanding		
Bleeding Problems			Drink alcohol: Amt:		
Diabetes Type I or 2			Use tobacco/Smoker: How many packs per day? _____		
Liver Disease/Jaundice/Hepatitis			Use Illegal drugs? How often?		
Aids/HIV			Have a living will or advance directive		
Kidney Problems			Use Aspirin regularly/occasionally		
Dialysis Peritoneal or Hemodialysis			Used Anticoagulants or blood thinners in past month		
Hiatal Hernia/Ulcer/Heartburn/GERDS			Used Cortisone/ steroids in past year		
Epilepsy/Seizures			Had recent dental work		
Stroke or Mini Stroke			Had recent cold or cough		
Back/Neck Problems			Had previous anesthesia		
Arthritis			Had a bad reaction to anesthesia		
Cancer			Had family with severe reaction to anesthesia		
Thyroid Disease			Are you aware of the risk of eating and drinking the day of your anesthesia?		
			Do you have any questions to discuss concerning anesthesia?		

List All Surgeries with Dates:

List All ALLERGIES/Reactions: (Are you allergic to Latex? Yes / No) _____

_____

MEDICATIONS: ☐ Filled out Universal Medication Form

Do you take insulin? If yes, what kind of insulin do you take, the amount, and what time:

DO NOT WRITE BELOW THIS LINE

Columbia Eye Surgery Center

Patient Label

OWNERSHIP

I,_____, understand that the following physician(s) on staff at Columbia Eye Surgery Center, Inc., providing medical services are, in fact, owners of the facility (Joshua G. Nunn, MD, Stephen A. Cross, MD, James Dickson, MD, Edward Mintz, MD, Robert Huff, MD, Mitchell Newman, MD, Holland Crosswell, III, MD, Edward Crosswell, MD, Garner Wild, MD, William Johnson, Jr, MD, Derek Barker, MD, Matthew Clary, MD, and Joshua Nunn, MD, Ryan N. Mercer, MD, and Stephen Cross, MD). I understand that I may choose to have my surgery in a facility that is not owned by physicians. I have been given this option and choose to have my surgery at Columbia Eye Surgery Center, Inc.

RELEASE OF INFORMATION

Columbia Eye Surgery Center, Inc. is hereby authorized to request and/or release any medical records, radiographic or diagnostic imaging results, pertinent to the healthcare of the above-named patient from, but not inclusive of, any insurance carrier, adjustor, attorney, or other health care provider. I understand that the information released to these facilities will be used to further or process my claim with my insurance company. This authorization is given with full knowledge that such disclosure may contain information of a confidential nature and may result in a denial of insurance coverage (in the event that claims are submitted to an insurance company on your behalf) for services rendered by the physicians of Columbia Eye Surgery Center, Inc. The information released will not be given, sold, or transferred to any other person not mentioned above. I understand that I am entitled to a photocopy of this authorization upon request.

ASSIGNMENT OF BENEFITS AND FINANCIAL RESPONSIBILITY

It is the policy of Columbia Eye Surgery Center, Inc. to collect payment one week prior to the surgery date. If you have a policy with a company with which we have a contract, we will gladly file your claim for you. However, you are expected to pay any co-pay or deductible one week prior to service date, unless arrangements have been made with the financial advocate. I understand that my insurance company may send payments for the services rendered to me. I hereby assign to Columbia Eye Surgery Center, Inc., all surgical, medical insurance and/or other benefits, if any, otherwise payable to me for the services. I agree to endorse the check(s) over to Columbia Eye Surgery Center, Inc. I understand that if I use the insurance proceeds for my personal use, I have committed insurance fraud. I hereby authorize and direct payment directly to Columbia Eye Surgery Center, Inc. from the obliger of said benefits. Further, I hereby assign, and convey Columbia Eye Surgery Center, Inc., unless charges for their services have been paid, so much of any cause of action or right of recovery and any payment proceeds relenting thereto, that I may have against any third party and direct my attorney, if one has been retained, as well as any person to insurance company obligated to pay damages or restitution to me, to deduct the amount of any outstanding bill for Columbia Eye Surgery Center, Inc. any settlement proceeds or other proceeds to be paid to me, prior to receiving said proceeds. I understand that payment is due one week prior to services unless prior arrangements have been made. I assign all medical and/or surgical benefits including major medical benefits for services provided to Columbia Eye Surgery Center, Inc. This assignment will remain in effect until revoked by me in writing. I am aware that any charges NOT COVERED by my insurance policy are my responsibility. I further understand that should any account with Columbia Eye Surgery Center, Inc. be turned over to a collection agency, I will be responsible for any additional interest on my outstanding balance or charges that may be incurred in the collection of my account.

PATIENT RIGHTS AND RESPONSIBILITIES and NOTICE OF PRIVACY PRACTICES

I, _____, have received and understand the Patient's Rights and Responsibilities and The Notice of Privacy Practices.

GRIEVANCE PROCEDURE

All alleged grievances will be fully documented, investigated, and reported to the chief executive officer of Columbia Eye Surgery Center, Inc.. Any substantial allegation will be reported to the State and/or Local authority. The grievance documentation will include the process for how the grievance was addressed. The patient will be provided a thorough written notice of the decision, within twenty (20) days of receipt of the grievance. Contact information for the State of South Carolina is included on the Patient Rights and Responsibilities. Patient will be kept up-to-date on the grievance status.

ADVANCED DIRECTIVES

I consent to all resuscitation measures as deemed necessary by my physician in the event of a life-threatening emergency. Columbia Eye Surgery Center, Inc. is not equipped to determine if there is a life-threatening event. The patient will be treated and stabilized, and transported to the hospital of choice by ambulance. I consent to emergency transfer to the hospital in case of the need for emergency hospital care. A copy of the advanced directive may be placed on the chart if the patient desires and forwarded to the hospital in the event of a transfer. Information regarding advanced directives is made available upon the patient's request. The admitting facility is not affiliated or in partnership with Columbia Eye Surgery Center, Inc..

I acknowledge that_____YES, I have signed an advanced directive, or _____ NO, I have not signed an advanced directive.

_____ _____ _____

Patient Signature Date Time

_____ _____ _____

Witness Date Time

UNIVERSAL MEDICATION FORM

Name: _____ DOB:____/____/____ Social Security #:_____/___/_____

Phone Number: (___)_____-_____Cell Number: (___)_____-_____Email Address:_____@____

Home Address: _____

Emergency Contact Information

1. Name:_____Phone: (__)_____-_____ Relationship: _____

2. Name:_____Phone: (__)_____-_____ Relationship: _____

Primary Care Doctor:_____ Phone Number: (___)_____-_____

Pharmacy:_____Address:_____Phone Number: (___)_____-_____

List all **Allergies** (describe reaction to each): _____

_____

_____

List all **medicines** you are currently taking (prescription, over-the-counter, herbals, and those taken as needed):

	Medication	Dose	Reason
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			

(Use back of sheet if necessary)

I, (Patient name),_____, confirm the list of medications provided are current.

_____ _____

Patient/Responsible Party/Significant Other Signature Date/Time

Responsible person (over 18) with you today who will be staying at the center during your procedure and who will be driving you home.

_____ _____ _____

Responsible Person Name Telephone Number Relationship

Patients, the Patient's Representative & the Patient's Health Care Surrogate have:

1. The right to considerate, respectful care, provided in a safe & dignified environment, free from all forms of mental & physical abuse or harassment as well as exploitation. The patient, the patient representative or the patient's surrogate may exercise these rights without regard to sex or cultural, economic, educational or religious background or the source of payment for care.
2. The right to full consideration of privacy concerning his/her medical care program. Health care professionals will conduct all confidential case discussions, consultations, examinations and treatments discretely. This includes the right to be advised of the reason for the presence of any individual involved in his/her healthcare
3. The right to confidential treatment of all communications and records pertaining to the patient's care and visit to the facility. (Except when the law requires, patients can approve or refuse the release of their records). If confidential communications and records are released, written consent by the patient shall be obtained. If the patient is physically or mentally unable to, written consent is required from the patient's responsible party.
4. The right to access to information contained in his/her medical record within a reasonable frame of time, (within 48 hours of request, excluding weekends and holidays), to include information regarding diagnosis, evaluation, treatment and prognosis. If it is medically unadvisable to give such information to the patient, a person designated by the patient or a legally authorized person shall have access to the patient's information.
5. The right to participate in the development and implementation of the patient's plan of care and to actively participate in decisions regarding this medical care. To the extent permitted by law, this includes the right to request and/or refuse treatment. This right includes information from the patient's physician about a patient's illness, the planned course of treatment, (including unanticipated outcomes), and prospects for recovery in terms the patient can understand. If treatment is refused, the patient shall be informed of the consequences of refusal of treatment, and the reason shall be reported to the physician and documented in the patient record.
6. The right to know the physician performing the procedure may have financial interest or ownership in this ASC. Disclosure of this information will be in writing and furnished prior to the start of the procedure in a language and manner the patient, the patient representative or the patient's surrogate understands.
7. The right to services provided at the facility and reasonable responses to any reasonable request the patient, the patient representative or the patient's surrogate may make for service.
8. The right to continuing healthcare requirements and instructions following the patient's discharge from the facility. The facility services are not intended for emergency care; therefore, all practitioners will direct after hours' care to the closest emergency room. The patient has the right for continuing care after hours or overnight. If care is not available at the ASC, the patient will be transferred to a hospital.
9. The right to examine and receive the fees for service. Upon request and prior to the initiation of care or treatment, the right to receive an estimate of the facility charges, potential insurance payments and an estimate of any co-payment, deductible, or other charges not paid by insurance.
10. The right to refuse to participate in experimental research.
11. The right to a written copy of the facility's policy on advance directives in a language and manner the patient, the patient's representative, or the patient's surrogate understands. Information concerning advance directives will be made available to the patient, the patient representative, or the patient's surrogate, including a description of the state laws regarding advance directives and official state advance directive forms if requested. Documentation of whether the individual has executed an advance directive will be placed in each patient chart.
12. The right to knowledge of the medical staff credentialing process, upon request.
13. The right to knowledge of the name of the physician who has primary responsibility for coordinating the patient's care and the names and professional relationships of other physicians and healthcare providers who will care for the patient and perform the procedure. The patient has the right to change the primary physician if another is available.
14. The right to understandable marketing or advertising methods used by the facility identifying the competence and skill of the organization.
15. The right to as much information about any proposed treatment or procedure as needed in order to give informed consent or to refuse the course of treatment. Except in emergencies, this information shall include a description of the procedure or treatment, the medically significant risks involved in the treatment, any alternate courses of treatment or non-treatment and the risks involved in each.
16. The right to know whether the patient's physician has appropriate liability insurance coverage or if the physician does not carry malpractice insurance.
17. The right to be advised of the facility's grievance process should the patient wish to communicate a concern regarding treatment or care delivered
18. Be informed of his/her right to discontinue care or to leave the facility against the physician's advice, as well as to be advised of any risks to the patient when discontinuing care or leaving the facility.
19. The right to appropriate assessment and management of pain.
20. The right to remain free from seclusion or restraints of any form not medically necessary or that are used as a means of coercion, discipline, convenience, or retaliation by staff.

21. The right to have a family member notified of the patient's admission as well as notification of the patient's personal physician, if requested.
22. The right to express spiritual and cultural beliefs.
23. The right to information regarding the patient's outcomes of care including unexpected outcomes.
24. The right to use a telephone and allowed privacy while making a call.
25. The right to be assured that reasonable safeguards will be provided for protection and storage of patients' personal belongings.
26. The right to a consultation and second opinion at your request and your expense.

Patient, the Patient's Representative & the Patient's Health Care Surrogate Responsibilities:

1. Responsible to provide accurate and complete information concerning the patient's present complaints, past illnesses and hospitalizations, and other matters relating to his/her health.
2. Responsible for reporting perceived risks in the patient's care and unexpected changes in the patient's condition to the responsible practitioner.
3. Responsible for asking questions concerning the information presented by a staff member about the patient's care or what the patient is expected to do
4. Responsible for following the treatment plan established by the patient's physician, including the instructions of nurses and other health professionals who carry out the physician's orders.
5. Responsible for keeping appointments and for notifying the facility or physician when the patient is unable to do so.
6. Responsible for providing healthcare insurance information and assuring the financial obligations of the patient's care are fulfilled as promptly as possible.
7. Responsible for the consequences if the patient refuses treatment or fails to follow the practitioner's instructions.
8. Responsible for following facility policies and procedures.
9. Responsible for being respectful and considerate of other patients and organizational personnel.
10. Responsible for being respectful of the belongings of others in the facility.
11. Responsible for the safekeeping of valuables, which should be left at home or with a designated caregiver. The ASC is not responsible for lost, stolen or broken personal items.
12. Responsible for providing a responsible adult driver to transport him or her from the facility.
13. Family members shall have the responsibility to be available to participate in decision-making and providing staff with knowledge of family whereabouts. Parents/family have the responsibility to continue their parenting role to the extent of their ability.

These rights and responsibilities listed here and on the previous page outline the basic concepts of service at the Columbia Eye Surgery Center. If you believe at any time our staff has not met one or more of the statements during your care here, please ask to speak to the Medical Director or Surgery Center Manager.
We will make every attempt to understand your complaint/concern. We will correct the issue you have if it is within our control, and you will receive a written response.

Jose A. Rodriguez, Surgery Center Manager, Columbia Eye Surgery Center

If you have concerns about patient safety or quality care in the Columbia Eye Surgery Center, you may contact any of the following organizations:

South Carolina Department of Health & Environmental Control:
https://dph.sc.gov/professionals/healthcare-quality/healthcare-facility-licensing/health-facility-and-cna-abuse

Phone: (800) 922-6735

Web site for the Office of the Medicare Beneficiary Ombudsman.

Medicare: 1-800-Medicare (Ombudsman) @ https://www.medicare.gov/basics/your-medicare-rights/get-help-with-your-rights-protections or
https://www.cms.gov/medicare/appeals-grievances/ombudsman-center

I _____, have been provided a copy of the patient's rights and responsibilities.

_____ _____
Patient or Representative Date

Patient Grievance Options

The patient has the right to register a complaint, in writing, to the Chief Executive Officer:
ATTN: R. Langston Spotts, Columbia Eye Surgery Center, 1920 Pickens Street, Columbia, South Carolina 29201

If the complaint is not resolved to the patient's satisfaction, the patient may file a grievance and include the following:
The patient should provide the physician or surgery center name, address, and the specific nature of the complaint. Any complaint registered will be kept confidential prohibiting retaliation should the grievance right be exercised.

COMPLAINTS AGAINST THE SURGERY CENTER: Department of Health & Environmental Control Bureau of Health Facilities Licensing, 2600 Bull Street, Columbia, South Carolina 29201
P: (803) 545-4370 F: (803) 545-4212
EMAIL: bhfl@dhec.sc.gov
ONLINE:
https://dph.sc.gov/professionals/healthcare-quality/healthcare-facility-licensing/health-facility-and-cna-abuse

COMPLAINTS AGAINST THE PHYSICIAN: Department of Labor, Licensing & Regulation, Office of Investigations and Enforcement, PO Box 11329, Columbia, South Carolina 29201
P: (803) 896-4470 F: (803) 896-4656
ONLINE: https://llr.sc.gov/fileacomplaint.aspx

COMPLAINTS AGAINST THE NURSING STAFF: South Carolina Board of Nursing, PO Box 12367, Columbia, South Carolina 29211
P: (803) 896-4550 F: (803) 896-4525
ONLINE: https://llr.sc.gov/nurse/discipline.aspx

COMPLAINTS AGAINST MEDICARE:
P: 1-800-MEDICARE
ONLINE: https://www.medicare.gov/claims-and-appeals/file-a-complaint/complaint.html

Columbia Eye Clinic, P.A.

Columbia Eye Surgery Center, Inc.
1920 Pickens St., Columbia, SC 29201
(803) 779-3070

Privacy Officer: Angie Strehlow **Effective Date: September 4, 2018**

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.

We care about our patients' privacy and strive to protect the confidentiality of your medical information at this practice. Federal legislation requires that we issue this official notice of our privacy practices. You have the right to the confidentiality of your medical information, and this practice is required by law to maintain the privacy of that protected health information. This practice is required to abide by the terms of the Notice of Privacy Practices currently in effect, and to provide notice of its legal duties and privacy practices with respect to protected health information. If you have any questions about this Notice, please contact the Privacy Officer at this practice.

Who Will Follow This Notice
Any health care professional authorized to enter information into your medical record, all employees, staff and other personnel at this practice who may need access to your information must abide by this Notice. All subsidiaries, business associates (e.g. a billing service), sites and locations of this practice may share medical information with each other for treatment, payment purposes or health care operations described in this Notice. Except where treatment is involved, only the minimum necessary information needed to accomplish the task will be shared.

How We May Use and Disclose Medical Information About You
The following categories describe different ways that we may use and disclose medical information without your specific consent or authorization. Examples are provided for each category of uses or disclosures. Not every possible use or disclosure in a category is listed.

For Treatment. We may use and disclose medical information about you to provide you with medical treatment or services. Example: In treating you for a specific condition, we may need to know if you have allergies that could influence which medications we prescribe for the treatment process.

For Payment. We may use and disclose medical information about you so that the treatment and services you receive from us may be billed and payment may be collected from you, an insurance company or a third party. Example: We may need to send your protected health information, such as your name, address, office visit date, and codes identifying your diagnosis and treatment to your insurance company for payment.

For Health Care Operations. We may use and disclose medical information about you for health care operations to assure that you receive quality care. Example: We may use medical information to review our treatment and services and evaluate the performance of our staff in caring for you.

Persons Involved in Your Care. We may disclose medical information about you to a relative, close personal friend or any other person you identify if that person is involved in your care and the information is relevant to your care. Example: if the patient is a minor, we may disclose medical information about the minor to a parent, guardian or other person responsible for the minor except in limited circumstances.

Required by Law. We will use and disclose medical information about you whenever we are required by law to do so. There are many state and federal laws that require us to use and disclose medical information. Example: state law requires us to report gunshot wounds and other injuries to the police and to report known or suspected child abuse or neglect to the Department of Social Services. We will comply with those state laws and with all other applicable laws.

National Priority Uses and Disclosures Made Without Your Consent or Authorization. When permitted by law, we may use or disclose medical information about you without your permission for activities that are recognized as "national priorities." The government has determined that under certain circumstances, it is so important to disclose medical information that it is acceptable to disclose medical information without the individual's permission. Some examples include:

- Law enforcement or correctional institution, such as required during an investigation by a correctional institution of an inmate;
- Threat to health or safety, such as to avert or lessen a serious threat;
- Workers' compensation or similar programs, such as for the processing of claims;
- Abuse, neglect or domestic violence, such as if you are an adult and we reasonably believe you may be a victim of abuse;
- Heath oversight activities, such as to a government agency to investigate possible insurance fraud;
- Court or legal proceedings, such as if a judge orders us to do so;
- Research organizations, such as if the organization has satisfied certain conditions about protecting the privacy of medical information;
- Coroner or medical examiner for identification of a body;
- Public health activities, such as required by the US Food and Drug Administration (FDA); and
- Certain government functions, such as using or disclosing for government functions like military and veterans' activities and national security and intelligence activities.

Uses and Disclosures of Protected Health Information Requiring Your Written Authorization
The following uses and disclosures of medical information about you will only be made with your authorization (signed permission) from you or your personal representatives:

- Uses and disclosures for marketing purposes.
- Uses and disclosures that constitute the sales of medical information about you.
- Most uses and disclosures of psychotherapy notes, if we maintain psychotherapy notes.
- Any other uses and disclosures not described in this Notice.

You have several rights with respect to medical information about you. This section of the Notice will briefly mention each of these rights. If you would like to know more about your rights, please contact our Privacy Officer.

Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you give us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will thereafter no longer use or disclose medical information about you for the reason covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care we have provided you.

Your Individual Rights Regarding Your Medical Information

Complaints. If you believe your privacy rights have been violated, you may file a complaint with the Privacy Officer at this practice or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized or discriminated against for filing a complaint.

To file a written complaint with us, you may bring your complaint directly to our Privacy Officer, or you may mail it to the following address:

100 Palmetto Park Blvd.
Lexington, SC 29072

To file a written complaint with the federal government, please use the following contact information:

Office of Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20201

Toll-Free Phone: 1-(877) 696-6775
Website: http://www.hhs.gov/ocr/privacy/hippa/complaints/index.html
Email: OCRComplaint@hhs.gov

Right to Request Restrictions on Uses and Disclosures. You have the right to request that we limit the use and disclosure of medical information about you for treatment, payment and healthcare operations. Under federal law, we must agree to your request and comply with your requested restriction(s) if:

1. Except as otherwise required by law, the disclosure is to a health plan for purpose of carrying out payment of healthcare operation (and is not for purposes of carrying out treatment); and,
2. The medical information pertains solely to a healthcare item or service for which the healthcare provided involved has been paid out-of-pocket in full.

Once we agree to your request, we must follow your restrictions (except if the information is necessary for emergency treatment). You may cancel the restrictions at any time. In addition, we may cancel a restriction at any time as long as we notify you of the cancellation and continue to apply the restriction to information collected before the cancellation.

You also have the right to request that we restrict disclosures of your medical information and healthcare treatment(s) to a health plan (health insurer) or other party, when that information relates solely to a healthcare item or service for which you, or another person on your behalf (other than a health plan), has paid us for in full. Once you have requested such restriction(s), and your payment in full has been received, we must follow your restriction(s).

Right to Request Confidential Communications. You have the right to request how we should send communications to you about medical matters, and where you would like those communications sent. To request confidential communications, you must make your request to the Privacy Officer at this practice. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted. We reserve the right to deny a request if it imposes an unreasonable burden on the practice.

Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually this includes medical and billing records but does not include psychotherapy notes, information compiled for use in a civil, criminal, or administrative action or proceeding, and protected health information to which access is prohibited by law. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the Privacy Officer at this practice. If you request a copy of the information, we reserve the right to charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by this practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept. To request an amendment, your request must be made in writing and submitted to the Privacy Officer at this practice. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request, In addition, we may deny your request if the information was not created by us, is not part of the medical information kept at this practice, is not part of the information which you would be permitted to inspect and copy, or which we deem to be accurate and complete. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Statements of disagreement and any corresponding rebuttals will be kept on file and sent out with any future authorized requests for information pertaining to the appropriate portion of your record.

Right to Accounting of Disclosures We Have Made. You have the right to receive an accounting (which means a detailed listing) of disclosures that we have made for the previous six (6) years. If you would like to receive an accounting, you may send us a letter requesting an accounting, fill out an Accounting Request Form, or contact our Privacy Officer. Accounting Request Forms are available from our Privacy Center.

The accounting will not include several types of disclosures, including disclosures for treatment, payment or healthcare operations. If we maintain your medical records in an Electronic Health Record (EHR) system, you may request inclusion of disclosures for treatment, payment or healthcare operations. The accounting will also not include disclosures made prior to April 14, 2003.

If you request an accounting more than once every twelve (12) months, we may charge you a fee to cover the costs of preparing the accounting.

Right to Request an Alternative Method of Contact. You have the right to request to be contacted at a different location or by a different method. For example, you may prefer to have all written information mailed to your work address rather than to your home address.

We will agree to any reasonable request for alternative methods of contact. If you would like to request an alternative method of contact, you must provide us with a request in writing. You may write us a letter or fill out an Alternative Contact Request Form. Alternative Contact Request Forms are available from our Privacy Officer.

Right to Notification if a Breach of Your Medical Information Occurs. You also have the right to be notified in the event of a breach of medical information about you. If a breach of your medical information occurs, and if that information is unsecured (not encrypted), we will notify you promptly with the following information:

- ❑ A brief description of what happened;
- ❑ A description of the health information that was involved;
- ❑ Recommended steps you can take to protect yourself from harm;
- ❑ What steps we are taking in response to the breach; and,
- ❑ Contact procedures so you can obtain further information.

Right to Opt-Out of Fundraising Communications. If we conduct fundraising and we use communications like the U.S. Postal Service or electronic email for fundraising, you have the right to opt-out of receiving such communications from us. Please contact our Privacy Officer to opt-out of fundraising communications if you chose to do so.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this Notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy. To obtain a paper copy of the current Notice, please request one in writing from the Privacy Officer at this practice.

Changes To This Notice

We resolve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice with the effective date in the upper right corner of the first page.