Millennium
Internal Medicine

BON SECOURS
ST. FRANCIS HEALTH SYSTEM

2 Innovation Drive Suite 300A, Greenville, SC 29607
Phone 864-365-0123, Fax 864-365-0133

Patient Information

Full Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Social Security # _____-_____-_____ Date of Birth: _____/_____/_____

E-mail: _____ Race _____ Sex: F M

Ethnicity: _____ Language: _____

Home Phone: (_____) _____-_____ Cell: (_____) _____-_____

Work: (_____) _____-_____

Do you have any cultural/religious considerations that we need to be aware of?

_____

_____

Are you hard of hearing? Yes or No Do you have vision problems? Yes or No

Other communication issues? _____

Living Will? Yes or No

POA: _____

Emergency Contact

Name _____ Relationship _____ Phone (____) ____-_____

Billing

Primary Insurance _____

Patient Relationship to Subscriber _____

Subscriber Name: _____

Date of Birth: _____/_____/_____

Medical Consent

I consent to the examination, treatment, and procedures which may be performed during the office visit, including emergency treatment considered necessary by the physician. If an invasive procedure is necessary, a specific consent form will be discussed with me at that time.

Signature _____ Date: _____

Relationship to Patient _____

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Disclosure of Medical Information

Patient Name _____ Date of Birth _____/_____/_____

I hereby authorize Millennium Internal Medicine to disclose my medical information to the following person(s). I understand I may revoke this release at any time.

Name _____ Relationship _____
May have access to: All information Appointments only Billing only Diagnosis only Lab Only

Name _____ Relationship _____
May have access to: All information Appointments only Billing only Diagnosis only Lab Only

Name _____ Relationship _____
May have access to: All information Appointments only Billing only Diagnosis only Lab Only

I hereby authorize Millennium Internal Medicine to leave messages regarding upcoming appointments on the following phone number: (_____) _____-_____

Notice of Privacy Practices

Millennium Internal Medicine is required to provide you with a notice that describes how information about you may be used and disclosed. These policies are defined in the "Notice of Privacy Policies and Practices" letter provided to you. **Please review it carefully.**

Rights of the Individual

- You may inspect or copy the information used or disclosed under this authorization by contacting Ashley Garrett at 864-365-0123.
- You may refuse to sign this authorization. If you refuse to sign, Millennium Internal Medicine will not deny you treatment.

I have reviewed this consent form, received the "Notice of Privacy Policies and Practices" and give my permission to Millennium Internal Medicine to use and disclose my health information in accordance with this consent form.

Print Patient Name _____

Signature of Patient/Representative _____

Relationship of Representative _____ Today's Date: _____

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Authorization for Release of Protected Health Information

Patient Name _____ Date of Birth ____/____/____ SSN ____-____-____

I hereby authorize Millennium Internal Medicine to release/obtain medical information
To _____ from _____

Name of Person/Organization _____
Phone Number (_____) _____-_____ Fax Number (_____) _____-_____
Address _____
City: _____ State: _____ Zip _____

Information to be released (mark all that apply)

___ All records
___ Office Visits
___ Billing Records
___ Medication List
___ Laboratory Reports
___ Ultrasound Results
___ Other (specify) _____
___ Other (specify) _____

- I understand that if the person or entity receiving this information is not covered by federal privacy regulations, this information will no longer be protected and may be re-disclosed.

- I understand that I may revoke this authorization at any time, but revocation will not apply to the information that has already been released. *Note: Request must be in writing and forwarded to the medical records department.*

- I understand that there may be a $15.00 service charge, and 0.65 for the first 30 pages and 0.50 for each additional page for obtaining the requested information.
  ** There will be a charge to lawyers, EMSI, and insurance companies.

- I understand that this authorization will expire in 90 days unless an earlier date is specified here ____/____/____

Print Patient Name _____

Signature of Patient/Representative _____

Relationship of Representative _____ Today's Date ____/____/____

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Thank you for choosing our practice! We participate with most insurance plans. Each plan has different benefits for you as well as different financial obligations. We will work with you and your insurance plan to determine what part of your fees for the medical care are covered by insurance and which parts are your responsibility.

Millennium Internal Medicines financial policies:

- Payment in full at time of service. (co-pays and balances)
- We accept cash, check, Master Card, Visa, American Express, or Discover. There will be a $25.00 charge on all returned checks.
- We do not extend professional courtesy discounts.
- It is your responsibility to check with your insurance company to determine covered benefits.
- **You will be charged a $50 no-show fee for any New Patient Appointment that is missed or canceled/rescheduled within 24 hours of the appointment. This fee will be collected before the New Patient Appointment is rescheduled.**
- You may be charged a $25 no-show fee for any follow ups and office visits missed and/or not canceled/rescheduled with a 24 hour notice.
- You may be charged a $50 no-show fee for any physical appointment missed or not canceled/rescheduled with a 24 hour notice.
- There is a $20 fee for completion of all disability forms and/or FMLA forms. Please allow 3-5 days for completion.
- As a courtesy to our patients you may elect to have your balance deducted from your bank account using your ATM debit card or credit card account. You may have up to three months to pay, with no service fee or interest charges.
- All account balances over 120 days will be turned over to an outside collection agency.
- A 25% collection fee will be added to your account balance if outside collection efforts are needed.
- We have a $20 charge for any prescriptions request for calling in or picking up.
- We do not accept Medicaid as a secondary payer. You will be responsible for any co-pays, co-insurance, or deductibles applicable to your primary policy.
- A parent or legal guardian must accompany patients who are minors. This accompanying adult is responsible for payment of the account.

I have read, understand, and agree to the above financial policy. I understand that charges not covered by my insurance company, as well as applicable co-pays and deductibles are my responsibility.

_____ _____

Printed Name Signature

_____

Date

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Medical History: (Please place a check below for any past or ongoing medical problems).

____ NONE OF BELOW

_____Allergies
_____AIDS/HIV
_____Amputation
_____Anemia
_____Anxiety
_____Arthritis
_____Asthma/COPD
_____Autoimmune Disease
_____Back Problems
_____Bleeding Disorders
_____Broken Bones
_____Cancer
_____Cholesterol Problems
_____Circulation Problems
_____Colon Polyps
_____Crohns/Ulcerative Colitis
_____Depression
_____Diabetes
_____Diverticulitis
_____Emphysema/COPD
_____Epilepsy/Seizures
_____Fibromyalgia
_____Ear Problems
_____GERD (Reflux)
_____GI Diseases
_____Hiatal Hernia
_____Headaches
_____Hearing Issues
_____Hernia
_____High Blood Pressure
_____Irritable Bowel/Spastic Colon
_____Infectious Disease
_____Kidney Problems
_____Muscular Disease
_____Osteoporosis
_____Pancreatitis
_____Phlebitis/Blood Clot
_____Psychiatric Problem
_____Paralysis
_____Pneumonia
_____Prostate Problems
_____Skin Rash/Eczema
_____Sleep Disorder
_____Stomach Ulcer
_____Stroke/TIA
_____Substance Abuse
_____Thyroid Problems
_____Tuberculosis
_____Urinary Tract Infections
_____STD
_____Visual Eye Problems
_____Other:_____
_____
_____

Past Surgical Procedures / Hospitalizations / Serious Injuries or Fractures

Operations/Hospitalizations/Injury	Month/Year	Operations/Hospitalizations/Injury	Month/Year

Family Medical History

Relative	Living or Deceased	Current age or age at death	Cause of Death	Health Issues (include mental health/Substance Abuse History)
Mother				
Father				
Sibling				

Social History		
Marital Status:	How many children:	Work Status: (Circle one): Employed/Unemployed / Retired / Disabled
What type of exercise do you perform, duration & frequency?		
Do you drink alcohol?	How much do you drink per week?	Do you smoke?
Are you a former smoker?	When did you quit smoking?	How much do you smoke per day?
Do you wear your seatbelt?	Do you have a fire extinguisher in your home?	Do you have a smoke detector in your home?

Other Physicians and Specialists
List below your other physicians

Doctor	Specialty
Example: Dr. Smith	*Cardiologist*

Please list all drug/food allergies & reaction: _____

_____

Desired Pharmacy for ***all*** medication needs:

Name: _____

Location: _____

Phone & Fax: _____

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Medications, Vitamins, and Herbal Supplements

Medication	Strength	Number of pills taken & frequency
Example: Tylenol	*500 mg*	*1 – taken twice daily*

Disease Prevention and Health Maintenance

	Month/Year		Month/Year		Month/Year
Flu Vaccine		Mammogram		Eye Exam	
Pneumonia Vaccine		Pap Smear		Heat Catheterizations	
Tetanus Vaccine		Colonoscopy		Endoscopy (EGD)	
EKG		Prostate Exam		Bone Density	

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Notice of Privacy Practices

This notice describes how your medical information may be used and disclosed and how you can get access to this information. Please review carefully.

Our Pledge to You

We understand that your medical information is personal. We are committed to protecting you medical information. We create a record of the care and services you received to provide quality care and to comply with legal requirements. This notice applies to all the records of your care that we maintain, whether created by our staff, physician, or treatment notes from other providers of medical care. We are required by law to:

- Keep medical information about you private.
- Give you notice of our privacy practices with respect to medical information about you.
- Follow the terms of the notice that is currently in effect.

Changes to this Notice

We may change our policies at any time. Changes will apply to medical information we already hold, as well as new information after the change occurs. Before we make a significant change in our policies, we will change our notices and post new notices. You may receive a copy of the current notice anytime. You will be asked to acknowledge in writing your receipt of this notice.

How We May Use and Disclose Your Medical Information

- We may use and disclose medical information about you for **treatment** (such as sending medical information about you to another physician as part of a referral); **to obtain payment for treatment** (such as sending billing information to your insurance company or Medicare); and **to support our health care operations** (such as calling patient test results, treatment options etc.)
- We may use or disclose medical information about you **without** your prior authorization for several reasons. Subject to certain requirements, we may give out medical information about you without prior authorization for **public health purposes, abuse or neglect reporting, funeral arrangements, organ donation, Worker's Compensation purposes and emergencies.** We also disclose medical information when **required by law**, such as in response to law enforcement or in response to valid judicial or administrative orders. We may also disclose medical information about you to a **friend, family member or personal representative as designated by you.**

Rights Regarding Your Medical Information

- In most cases, **you have the right to look at or get a copy of medical information that we use** to make decisions about your care when you submit a written request. We are committed to acting in good faith in responding to your access request, and to the requirements of the HIPAA privacy rules and any other federal or State statues or regulations that may be stricter than HIPAA in granting access to personal health information. If you request copies **we may charge a fee for copying, mailing or other related supplies.** If we deny your request to review or obtain a copy, you may submit a written request for a review of that decision.
- If you believe that information in your record is incorrect or if important information is missing, **you have the right to request that we correct the records** by submitting a request in writing that provides your reason for requesting amendment. We could deny your request to amend a record if we did not create the information; if it is not part of the medical information that we maintain; or if

we determine that the record is accurate. You may appeal, in writing, our decision not to amend a record.

- **You have the right to a list of those instances where we have disclosed medical information about you**, other than for treatment, payment, health care operations, or where you specifically authorized a disclosure. This request must be submitted to us in writing. The request must state the time period desired for the accounting which must be less than a six-year period and starting after April 14, 2003.
- **You have the right to request that medical information about you be communicated to you in a confidential manner**, such as sending mail to an address other than your home, by notifying us in writing of the specific way or location for us to use to communicate with you.

Other Uses of Medical Information

In any other situation not covered by this notice, we will ask for your written authorization before disclosing medical information about you. If you choose to authorize use or disclosure, you can later revoke that authorization by notifying us in writing of your decision. You may request, in writing, that we not disclose medical information about you for treatment, payment, or health care operations unless required by S.C. law. However, **YOU WILL BE RESPONSIBLE FOR YOUR BILL.**

- **You have a right to amend your personal medical information.** We will consider the request but WE ARE NOT LEGALLY REQUIRED TO ACCEPT IT. We will inform you of our decision on your request.

Complaints

If you are concerned that your privacy rights have been violated, or you disagree with a decision we made about access to your records, you may contact Ashley Garrett at (864) 365-0123.

You may also send a written complaint to or call:
(202) 619-0257
The U.S. Department of Health & Human Services Office of Civil Rights
200 Independence Ave
Washington, D.C. 20201

Under no circumstances will you be penalized or retaliated against for filing a complaint.

If you have any questions you may contact Ashley Garrett, Administrator:
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2 Innovation Dr.
Suite 300A
Greenville, SC 29607
(864) 365-0135