PRISMA HEALTH®

Patient Information

(please print)
Full legal name: _____ Preferred name: _____
Last *First* *Middle*

Date of birth: _____ SS#: _____
Month/Day/Complete year

Sex at birth: ☐ Male ☐ Female ☐ Intersex

Gender identity: ☐ Man ☐ Woman ☐ Transwoman ☐ Transman ☐ Nonbinary ☐ Another unlisted

What are your pronouns? ☐ He/Him ☐ She/Her ☐ They/Them ☐ Another _____

Primary care physician: _____

Preferred pharmacy name: _____ Phone number: _____

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Life partner ☐ Legally separated

Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Non-Latino ☐ Refused/Decline

Race: ☐ Caucasian (white) ☐ American Indian ☐ African American (Black) ☐ Hispanic ☐ Biracial ☐ Asian ☐ Other ☐ Unknown

Home address: _____ City: _____ State: _____ ZIP: _____

Mail to address: _____ City: _____ State: _____ ZIP: _____

County: _____ Home phone: ( ) _____ Cellphone: ( ) _____

Preferred language: _____ Email: _____

Veteran: ___Yes ___No ___Unknown Religion: _____

Guarantor information *(If guarantor is self, skip to emergency contact)*
Parent/guardian presenting minor child for treatment will be listed as the guarantor. If 18 or older, patient will be listed as guarantor and does not have to complete this section. The guarantor will be responsible for any balance due.

Name: _____ Patient relation to guarantor: _____
Last *First* *Middle*

Home phone: ( ) _____

Date of birth: _____ SS#: _____ Cellphone: ( ) _____

Home address: _____ City: _____ State: _____ ZIP: _____ Country: _____

Mail to address *(if different)*: _____ City: _____ State: _____ ZIP: _____ Country: _____

Emergency contact *(Pediatric patients, please list someone other than parent(s)/guardian)*

Primary contact name: _____ Home phone: ( ) _____

Patient relation to emergency contact: _____ Cellphone: ( ) _____

Secondary contact name: _____ Home phone: ( ) _____

Patient relation to emergency contact: _____ Cellphone: ( ) _____

Employment

Patient employer: _____ Work phone: _____ Ext: _____

Address: _____ City: _____ State: _____ ZIP: _____

Employment status: ☐ Full time ☐ Part time ☐ Self-employed ☐ Active military ☐ Student full time ☐ Student part time ☐ Retired date _____ ☐ Disabled ☐ Not employed ☐ Unknown

(Pediatric patients only) Parent/Guardian & immediate family information

Mother *(If the address, phone numbers and employer information are the same as guarantor, please indicate same.)*

Full name: _____ Nickname: _____
Last *First* *Middle*

Date of birth: _____
Month/Day/Complete year

SS#: _____

Home address: _____ City: _____ State: _____ ZIP: _____
(if different from patient)

Home phone: _____ Cellphone: ( ) _____

Employer: _____ Work phone: ( ) _____ Ext: _____

Father *(If the address, phone numbers and employer information are the same as guarantor, please indicate same.)*

Full name: _____ Nickname: _____
Last *First* *Middle*

Date of birth: _____
Month/Day/Complete year

SS#: _____

Home address: _____ City: _____ State: _____ ZIP: _____
(if different from patient)

Home phone: _____ Cellphone: ( ) _____

Employer: _____ Work phone: ( ) _____ Ext: _____

Patient name _____ DOB _____

(Pediatric patients only) Brothers, sisters & other family members

Full name	*M or F*	*Date of birth*	*Relationship*	*Lives with child*	
				Yes	No
				Yes	No
				Yes	No
				Yes	No

☐ **Check here if no insurance. And skip to authorization (below).**

Accident information

Is visit the result of an accident? (Examples: auto accident, workers compensation, etc.) ☐ Yes ☐ No

Type of accident: _____ Date of accident: _____ County of accident: _____

Primary insurance information

SUBSCRIBER: This is the person who carries the insurance. If subscriber is the patient, skip to insurance co. name field.

Subscriber's name on card: _____ Date of birth: _____
Month/Day/Complete year

Patient relationship to subscriber: _____ Sex: ☐ Male ☐ Female

If address and phone number is same as patient, please indicate same.

Address: _____ SS#: _____

City, state, ZIP: _____ Home phone: _____

Employer: _____ Work phone: _____ Ext. _____

Insurance co. name: _____ **Phone:** _____

Policy/Cert #: _____ **Group no.:** _____ **Effective date:** _____

Subscriber Status: ☐ **Full time** ☐ **Part time** ☐ **Self-employed** ☐ **Active military** ☐ **Student full time**
☐ **Student part time** ☐ **Retired date** _____ ☐ **Disabled** ☐ **Not employed**

Secondary insurance information

SUBSCRIBER: This is the person who carries the insurance. If subscriber is the patient, skip to insurance co. name field.

Subscriber's name on card: _____ Date of birth: _____
Month/Day/Complete Year

Patient relationship to subscriber: _____ Sex: ☐ Male ☐ Female

If address and phone number is same as patient, please indicate same.

Address: _____ SS#: _____

City, state, ZIP: _____ Home phone: _____

Employer: _____ Work phone: _____ Ext. _____

Insurance co. name: _____ **Phone:** _____

Policy/Cert #: _____ **Group no.:** _____ **Effective date:** _____

Subscriber status: ☐ **Full time** ☐ **Part time** ☐ **Self-employed** ☐ **Active military** ☐ **Student full time**
☐ **Student part time** ☐ **Retired date** _____ ☐ **Disabled** ☐ **Not employed**

Authorization

I authorize medical evaluation and treatment, and release of information for insurance/medical purposes concerning my illness and treatment. I hereby authorize payment from my insurance company to Prisma Health for services rendered. I will be responsible for any amount not covered by my insurance.

Signature of patient/guardian/guarantor: _____ **Date:** _____

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Permission to Treat

Patient's name: _____ DOB: _____ MRN: _____

1. I consent to this entity performing as applicable: blood draws, medications, tissue disposal/donation, examinations, treatments, lab tests, therapy, transportation, evaluation and treatment services, procedures, and anesthetics as may be necessary in accordance with the judgment of the authorized physicians and/or clinicians, including appropriately supervised students, residents, and telehealth providers. **Treatment may be provided by authorized employees of Prisma Health and the University of South Carolina.** I acknowledge that no guarantee can be made concerning the results of treatments.
2. I acknowledge receipt of Notice of Privacy Practices, which can be found in this packet.
3. I would like to receive email invitations to the MyHealth online patient portals.
4. I acknowledge that my photograph may be taken for identification purposes, that cameras and video cameras may be used for observation and medical documentation purposes, and that the images are the property of this entity unless I withdraw my consent in writing.
5. I give permission to share my electronic medical record among my health providers and obtain medication history through a Provider Health Information Exchange (HIE), which will follow state and federal laws regarding access by medical providers of any protected information. I may opt out of the HIE and continue to receive care.
6. I consent to the use of the electronic prescription system, which allows prescription history and related information to be electronically shared between my providers and my pharmacies.
7. For the protection of myself and others, I give permission to have blood drawn and tested for infectious diseases including, but not limited to, HIV (AIDS virus) and hepatitis.
8. I understand that certain circumstances require mandatory disclosure to organizations such as the state health department and Department of Health and Environmental Control and that this entity participates in the South Carolina Dept. of Health's statewide immunization registry, which complies with federal health information privacy laws.
9. I give permission to send or fax childhood immunization records to schools or my employer, upon request.
10. I acknowledge receipt of the Patient Financial Billing Policy. In the event that I fail to make payment or comply with payment arrangements, collection measures may be initiated and my credit report can be obtained.
11. By listing a phone number, I give permission to leave messages on my answering machine/voicemail.
    Phone #_____
    By listing an email or mobile number, I give permission for an unsecured appointment reminder to be emailed and/or texted to me at _____. This will only include patient's first name, appointment date/time and location.
    By listing a phone number, I give permission to leave messages on my voicemail at my place of employment.
    Phone #_____
12. I have an Advance Directive (Living Will or Healthcare Power of Attorney) (Circle one) YES or NO
    I have been offered information or assistance regarding Advance Directive (Circle one) YES or NO or N/A
13. I understand that this entity is not responsible for the loss or damage of any valuables. Any valuables not claimed within 30 days of my visit, including electronic devices, may become the property of this entity.

I FULLY UNDERSTAND AND AGREE TO THE CONDITIONS CONTAINED IN THIS FORM.

_____ _____

Signature of patient or legally qualified representative | Date/Time

_____ _____

Printed name of patient or legally qualified representative | Relationship to patient

_____ _____

Prisma Health representative | Date/Time

PRISMA HEALTH®

Authorization for Disclosure of Medical Information

Patient full name (PRINT)_____DOB_____MRN _____

Authorization for disclosure of medical information: The privacy of your medical information is important. We will discuss your medical condition with person(s) you designate.

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHOM? *(Check and complete one)*

YES The provider may discuss my medical condition with the following family member or other individual:

_____

_____

NO The provider may not discuss my medical condition with any family member or other individual.

You may revoke/cancel or modify/change the above designation, but the revocation or modification must be in writing.

NOTE: This designation does not give the above named individuals the right to make health care decisions for you. If at any time you are unable to consent to care or treatment, we will follow the procedure set forth in the South Carolina Adult Health Care Consent Act.

Communication: Please provide phone number(s) where we can reach you (by providing a number you also authorize Prisma Health to leave you voicemails at the number(s) listed):

Home:_____Cell:_____Work: _____

Note: *An automated appointment reminder system may call the number listed in our database.*

Signature: I hereby authorize the disclosure of my medical information as described above.

Patient/Patient's representative signature:_____Date:_____Time:_____

PRINT name (if patient's representative): _____

Relationship to patient (if patient's representative):_____

Prisma Health representative:_____Date:_____Time:____

PRISMA HEALTH®

Patient Financial Billing Policy

Patient's name_____ DOB_____

It is the policy of Prisma Health Medical Group (Medical Group) to provide the most efficient and reasonable health care services. Therefore, it is necessary for us to have a Patient Financial Billing Policy stating our requirements for payment for services provided to all patients.

Patients are responsible for the payment of all services provided by the Medical Group.

Self-pay policy

- If you are a self-pay patient, you will be required to pay at time of service.
- In addition, any remaining balance on your account will be collected.

Insurance policy

- If we have accurate and complete insurance information, we will file the claim with your insurance carrier as a courtesy to you.
- If a service is provided that is not covered by your insurance carrier, you may be responsible for the balance due in full.
- Deductibles, copayments, and coinsurance will be collected at time of service.
- In special cases, we may need your help in contacting your insurance carrier for the payment of your services.
- If you do not want the Medical Group to file your insurance, please inform a team member at check-in. Services not filed to your insurance carrier will be considered self-pay and payment is due at time of service.

Past due balances

- All overdue patient balances will be sent to collections.
- You hereby authorize **the Medical Group** or any of their associates, including collection agencies and/or law firms, to contact you utilizing any of the demographic information provided. This includes, but is not limited to your address, email and/or phone numbers (including your cell phone number), either directly, by automated dialer or voice messaging to discuss the collection of all debts arising out of this treatment.

To help in this policy, we ask that you assist us by:

- Providing accurate and complete information on yourself, the insurance subscriber (if different than yourself), and your insurance carrier(s).
- Presenting your photo identification card and insurance card(s) at the time of service.
- Making the appropriate payment at the time of service, whether it is a deductible, copay, coinsurance, or for the full amount.

We ask that you do not discuss your account balance or financial aspects with the physician(s) or medical team members. Please discuss any additional account information with our customer service team members at 803-296-7320.

_____ _____

Patient's signature or legally qualified representative Date/Time

_____ _____

Patient/Guardian Print Name Relation to patient

_____ _____

Prisma Health Medical Group representative Date/Time

PRISMA HEALTH®

MyHealth Education Sheet

We know you are busy. That is why Prisma Health Medical Group's physician practices are offering a way for you to manage your healthcare online.

MyHealth is a convenient and easy-to-use patient portal that allows you to:

- Communicate with your doctor's office
- Refill prescriptions
- Review your lab results
- View your personal health information

Rest assured that MyHealth is encrypted and password protected, too, so health data remains secure.

(Please note that separate invitations are required for each portal and they may be accessed at https://phuscmg.org/patient-portals)

OneChart

Select Palmetto Health-USC Medical Group practices.

MyHealth Physician

Former Palmetto Health Physician Practices provider portals.

UNIVERSITY OF SOUTH CAROLINA

Former USC Specialty Clinics provider portals.

MyHealth Palmetto Heart

Access Palmetto Heart's portal.

MyHealth Orthopedics

Former Palmetto Health Orthopedics provider portal.

MyHealth Tuomey

Former Palmetto Health Tuomey Physician Practice provider portal.

PRISMA HEALTH®

PrismaHealth.org

Prisma Health–Midlands Notice of Privacy Practices

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.

Prisma Health–Midlands participates as an organized healthcare arrangement (OHCA), which is a clinically integrated care facility where individuals typically receive healthcare from more than one healthcare provider, some of whom may not be employed by Prisma Health–Midlands. Prisma Health–Midlands's medical staff, practitioners and non-practitioners who provide services in any Prisma Health–Midlands facility may fall under the Notice of Privacy Practices and may use and/or share your health information for treatment, to obtain payment for treatment, for administrative purposes, to evaluate the quality of care that you receive and for any and all other purposes described in this notice.

Understanding your health record/information

A record is created each time you receive services from Prisma Health–Midlands, a physician or other healthcare provider associated with us. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a basis for planning your care and treatment. It is communicated among the many health professionals who contribute to your care and enables you or a third-party payer to verify that services billed were actually provided. Your medical record is a legal document describing the care you received. It is a tool we use to educate health professionals and to assess and continually work to improve the care we provide and the outcomes we achieve. Your medical record may be a source of data for medical research, public health initiatives and facility planning.

The purpose of this Notice of Privacy Practices is to assist you in understanding what is in your medical record and who, what, when, where and why others may access your health information. This document will assist you in making more informed decisions when authorizing disclosures of your health information.

Your health information rights

Although your health record is the physical property of the healthcare practitioner or facility that compiled it, the information belongs to you. You have rights afforded to you by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), a federal regulation (42 CFR Part 164). These rights include:

- The right to request a restriction on certain uses and disclosures of your information. Prisma Health–Midlands is not required to agree to a requested restriction, unless related to payment. Requests for restrictions should be sent to the facility's Health Information Management department or the specific department maintaining your health information.
- The right to obtain a paper copy of our Notice of Privacy Practices upon request. The Notice of Privacy Practices may be obtained from Prisma Health–Midlands' registration areas.
- The right to inspect and obtain a copy of your medical record in any requested format supported by the organization. Prisma Health–Midlands charges a fee for copying medical records in accordance with South Carolina law. Copies may be obtained by contacting the facility's Health Information Management department or the specific department maintaining your health information.
- The right to amend or correct your medical record. However, Prisma Health–Midlands is not required to agree to the requested amendment under certain circumstances. Requests for amendments should be sent to the facility's Health Information Management department or the specific department maintaining your health information.
- The right to obtain an accounting of certain disclosures of your health information. An accounting of disclosures can be obtained from the facility's Health Information Management department. We will provide you with one free accounting each year. For subsequent requests, we will charge a $25 fee per request.

- The right to obtain an access log detailing up to three (3) years of electronic transactions related to your medical record beginning Jan. 1, 2014. An access log can be obtained from the facility's Health Information Management department. We will provide you with one free accounting each year. For subsequent requests, we will charge a $25 fee per request.
- The right to request communication of your health information by alternative means or at alternative locations.

Requests for alternative communications should be made to the Health Information Management department or the specific department maintaining your health information. Prisma Health–Midlands will agree to send information in a secure manner only.

Our responsibilities

Prisma Health–Midlands is required to:

- Maintain the privacy of your health information
- Provide you with a Notice of Privacy Practices describing our legal duties and practices with respect to information we collect and maintain about you
- Abide by the terms of the Notice of Privacy Practices
- Notify you if we are unable to agree to a requested restriction
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations
- Notify you that you must opt-in to receive electronic privacy notices, such as via email

Prisma Health–Midlands reserves the right to change our health information practices, policies and/or procedures at any time and to make the new provisions effective for all protected health information we maintain. You will be informed of such changes at the time of your next visit when you receive our Notice of Privacy Practices. The most recent version of our Notice of Privacy Practices will be posted in each of the facilities.

We may use and disclose your health information for purposes of treatment, payment and healthcare operations.

Treatment

For example: Information obtained by a nurse, physician or other member of your healthcare team will be recorded in your record and used to determine the course of your treatment. Your physician will document in your record his or her expectations of the members of your healthcare team. Members of your healthcare team will then record the actions they took and their observations. In that way, the physician will know how you are responding to treatment. We also will provide your physician or a subsequent healthcare provider with copies of various reports that should assist him or her in treating you once you are discharged from this facility.

Payment

For example: A bill may be sent to you and/or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures and supplies used. This information will be used for billing, claims management and collection activities to obtain payment for services provided to you. You may request that Prisma Health–Midlands withhold health information from your insurance provider if you make payment in full and not via another payment source, such as insurance.

Healthcare operations

For example: Members of the medical staff and the risk management and quality improvement teams may use your health information to assess the care and outcomes in your case and others like it. This information then will be used in an effort to continually improve the quality and effectiveness of the healthcare and services we provide.

Other permitted or required uses and disclosures of your health information

Appointments: Prisma Health–Midlands may call or send information to remind you of an upcoming appointment or to reschedule an appointment. When appropriate, a message will be left on your answering machine. The content of that message will be kept as generic as possible to protect your privacy.

Business associates: There are some services provided in our organization through contracts with business associates. Examples include answering services, collection agencies, medical record storage companies and a copy service we use when making copies of the medical record. When these services are contracted, we may disclose your health information to our business associates so that they can perform their job and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associates to appropriately safeguard your information.

Communication with family: Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person whom you identify, health information relevant to that person's involvement in your care or payment related to your care. Generally, we will provide you the opportunity to object to such disclosures; however, in certain circumstances, we

may use and disclose your health information for these purposes without providing you the opportunity to object.

Coroner: We may disclose health information to coroners, consistent with applicable law, to carry out their duties.

Correctional institution: If you are an inmate of a correctional institution, we may disclose to the institution or agents thereof health information necessary for your health and the health and safety of other individuals.

Decedents: A decedent's health information is under privacy protection for 50 years after death. Prisma Health–Midlands may continue communicating with relevant family and friends after an individual's death to disclose health information to those involved in a decedent's care or for payment.

Directory: Unless you notify us that you object, we will use your name, location in the facility and general condition for directory purposes. This information can be provided to people who ask for you by name, including the media. If you provide us with your religious affiliation, we can provide that to members of the clergy.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs or replacement.

Fundraising: We may use your information to contact you to raise funds for the benefit of Prisma Health–Midlands. Prisma Health–Midlands is required to offer the option to decline or opt-out of fundraising. Prisma Health–Midlands may not make fundraising communications after an individual opts out, but may provide a method of opting back in.

Funeral directors: We may disclose health information to funeral directors, consistent with applicable law, to carry out their duties.

Genetic information: Prisma Health–Midlands may provide genetic information to your health insurance plan, but genetic information may not be used by health insurance plans for underwriting purposes. Examples of genetic information include the individual's genetic tests; genetic tests of family members of the individual; manifestation of a disease or disorder in family members of the individual; or any request for, or receipt of, genetic services, or participation in clinical research that includes genetic services, by the individual or any family member of the individual.

Government functions: Your health information may be disclosed for the purpose of protecting public officials, national security and intelligence activities and other specialized government functions, as necessary.

Immunization records: Prisma Health–Midlands will obtain your permission to release student immunization records to schools, but a formal authorization is not required.

Marketing: We may use your information to contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you. From time to time, your healthcare provider or designee may contact you to request your permission to participate in health education and/or promotion. If Prisma Health–Midlands receives compensation for a marketing-related activity, your authorization is required.

Military and veterans: If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We also may release medical information about foreign military personnel to the appropriate foreign military authority.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, and inform them of your location and general condition.

Organ procurement organizations: Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant. This is to facilitate a patient or family's request to be an organ or tissue donor.

Photographing and videotaping: Prisma Health may take photographs, video or audio recordings of you only in the course of and for purposes of your treatment. Prisma Health will only use any photographs, videos or audio recordings internally for diagnosing, treating or for healthcare operations.

Post-treatment follow-up: Prisma Health–Midlands may contact you to check on your health status or to ensure we have answered all of your questions. If you participate in post-treatment support groups, you may be given tools for your convenience that inform others of your diagnosis and/or treatment.

Public health: As required by federal, state and local law, we may disclose your health information to public health or legal authorities charged with preventing, reporting or controlling disease, injury, disability or for other health oversight activities.

Required by law or law enforcement: Prisma Health–Midlands may use and disclose information about you as required by law. Your information also may be used and disclosed for law enforcement purposes, as required by law or in response to a court order. For example, we may disclose information for the following purposes:

- For judicial and administrative proceedings pursuant to legal authority
- To report information related to victims of abuse, neglect and/or domestic violence
- To assist law enforcement officials in their law enforcement duties
- For purposes of governmental investigation

Research: We may disclose information to researchers when their research has been approved by an Institutional Review Board and/or Privacy Board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Serious threat to health or safety: To avert a serious threat to health or safety, we may use and disclose medical information about you when necessary. Any disclosure, however, would only be to someone able to help prevent such a threat.

Telephone contacts: We may contact you by telephone to provide you with test results, return your call, answer questions or obtain additional information.

Workers' compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to Workers' Compensation or other similar programs established by law.

Other uses and disclosures of your health information will be made only with your written authorization. You may revoke your authorization to use or disclose health information at any time except to the extent that action already has been taken.

Breach notification: Prisma Health–Midlands is required to protect the privacy of your health information. In the unfortunate event that your health information is breached, Prisma Health–Midlands will provide notification to you without unreasonable delay.

For more information or to report a problem

If you have questions or concerns about Prisma Health–Midlands's health information policies or practices, you can contact Prisma Health–Midlands's Privacy Line at **1-800-883-0844**. If you believe your privacy rights have been violated, you may file a complaint with Prisma Health–Midlands using the phone number listed or with the Secretary of Health and Human Services via the Office for Civil Rights. There will be no retaliation by Prisma Health–Midlands for filing a complaint.

Effective date: April 14, 2003
Revised: Oct. 6, 2009
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