Palmetto Primary Healthcare PLLC

New Patient Packet

4850 Fayetteville Rd., Suite G., Lumberton, NC 28358
Phone: (910) 338-2222

WELCOME!

Dear New Patient:

We would like to welcome you to our practice. Our goal is to make your experience with us as pleasant as possible. In order to help us meet this goal we have listed some helpful hints to benefit you as well as help our practice operate efficiently.

Medications – Please bring ALL medications and supplements in the bottle or a current medication list with you to all office appointments.

New Patient Registration – New patients should arrive 15 mins early for in-office visits to complete any the registration process unless otherwise instructed. Please bring photo ID and insurance cards. We also have an electronic ***New Patient Registration and Health History*** to obtain a summary your health history that we ask you to complete **within 72 hours of scheduling your first appointment**. Our practitioner will review this information prior to your appointment. Completing and submitting this form with insurance information electronically will save you time in the office and make your waiting time as short as possible.

Billing and Insurance – If your insurance plan has a co-pay, co-insurance, or deductible please be prepared to pay at the time of service each visit. We ask that you always make our staff aware of changes in address, phone numbers, and insurance as you sign in.

If you have insurance for which we are contracted with, we will gladly process your claim, but we request that you pay your estimated portion when services are rendered.

Phone Calls – We want to be responsive to your needs. Please call if you need to speak with a healthcare practitioner or their assistant during office hours regarding an urgent concern.

Prescription Refills – Please ask your healthcare practitioner or nurse for all of your prescription refills at the time of your visit. This will ensure you have all of your needed medications. If you are needing a refill before your scheduled visit you can contact our office during business hours. Any refill requests will be handled within 72 hours (3 business days) of our staff receiving the request.

Lab Results and Test Results – If you have lab work or test results pending, it is not necessary to call our office unless you have been instructed to do so by your healthcare practitioner. Our healthcare practitioner will discuss with you with the results during your scheduled face-to-face visit with the practitioner.

If you have any questions about any part of the registration process, or anything pertaining to your appointment, please feel free to call us. We are here to serve you.

Sincerely,

Palmetto Primary Healthcare, PLLC

CLINIC POLICIES (Pg.1)

1. Appointment Confirmation Policy

At Palmetto Primary Healthcare, PLLC, we are committed to delivering quality, urgent and comprehensive health care. We greatly value our scheduled patients as they allow us to provide quality care in a timely manner.

When you schedule an appointment, we reserve that time just for you with our clinical staff and doctor. We are committed to honoring the appointment time of our scheduled patients, so it is critical that you confirm your appointment within 24 hours of your appointment time and that you arrive no later than 15 minutes of the scheduled time.

Our Responsibility to You:

• We promise to work with you to find the time that works best for you.

• We will call/, text, and/or email you in advance to remind you of your appointment and to ensure we are prepared to make your experience as pleasant as possible.

Your Responsibility to Us:

• **Appointments MUST BE CONFIRMED within 24 hours of the appointment time** by responding to either a confirmation call, text, or email.

• If you miss our confirmation reminder or need a different appointment time, please contact us as soon as possible to either confirm or reschedule based upon current availability. You may respond to a text or email to confirm your appointment if the option is available, but you MUST respond to confirm by 5:00 PM EST the day prior to your appointment.

• Arrive on time or early for your appointment. We will not hold your reserved time if you are more than 15 minutes late.

What happens if you don't confirm your appointment within 24 hours of the scheduled time and/or you are late for your appointment?

If you arrive for your appointment that has not been confirmed and/or you are more than 15 minutes late for your appointment, we promise to do our best to work with you to reschedule your appointment for routine health maintenance by finding the time that works best for you.

Additionally, failure to comply with the Appointment Policy is a violation of our 24-Hour Cancellation Policy.

2. Cancellation/ No Show Policy for Doctor Appointment

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, failing to cancel an appointment via phone or our patient portal, may be preventing another patient from getting much needed treatment.

After two No-Show appointments or two failures to cancelled at least 24 hours in advance you will be charged a **$25** fee; this will not be covered by your insurance company. Four No-Show appointments will subject you to possible dismissal from the practice.

CLINIC POLICIES (Pg.2)

3. Scheduled Appointments

We understand that delays can happen however we must try to keep the other patients and healthcare practitioners on time.

If a patient is 15 minutes past their scheduled time for an in-office visit and/or shows up after their appointment time we will have to reschedule the appointment to a later time or date.

4. Controlled Substances

As a notice to all existing and potential new patients, we feel it is important to notify you that due to the Rules and Regulations for Healthcare Practitioners set forth by the state of North Carolina, our healthcare practitioner does **NOT** prescribe scheduled II/III OPIATE medications on a long-term basis for the treatment of chronic conditions for any reason. This includes hydrocodone, oxycodone, morphine, fentanyl, methadone, oxymorphine, and hydromorphone.

I have read and understood the Clinic Policies for Palmetto Primary Healthcare, PLLC

Patient's Signature: _____

Printed Patient Name: _____

Date: _____

If this authorization is signed by a personal representative on behalf of the patient, complete the following:
Personal Representative's Name:_____
Relationship to Patient:_____

Office Use Only:
Recorded by:_____Date:_____

Patient Information Form for Palmetto Primary Healthcare, PLLC (PPHC, PLLC)

Demographics

Please print, complete all fields, and sign.

Office Use Only: Recorded By: _____ Date: _____

Patient Last Name_____ Suffix_____ First_____ Middle_____

Birth Gender: _____ Gender Indentity: _____ SSN_____ Birthdate

Billing or PO Box Address

Street_____ Apt/Bldg/Lot_____

City_____ State_____ Zip_____

County_____ Country: US☐ Other_____

Secondary or Physical Address

Street_____ Apt/Bldg/Lot_____

City_____ State_____ Zip_____

County_____ Country: US: ☐ Other_____

Preferred Pronoun(s)_____ Marital Status_____ Race_____ Language_____ Ethnicity_____

1-Primary Insurance Name _____

Policy ID#_____ Group#_____

Insurance Address_____

City_____ State_____ Zip_____

Policy Holder (Sponsor) Name_____

Birthdate_____ Sex_____ Phone_____

Street _____ Apt/Bldg/Lot_____

City_____ State_____ Zip_____

Policy Holder's Relationship to Patient_____

Employer_____

2-Secondary Insurance Name _____

Policy ID#_____ Group#_____

Insurance Address_____

City_____ State_____ Zip_____

Policy Holder (Sponsor) Name_____

Birthdate_____ Sex_____ Phone_____

Street _____ Apt/Bldg/Lot_____

City_____ State_____ Zip_____

Policy Holder's Relationship to Patient_____

Employer_____

Patient Contact Information

Home Phone_____ Cell_____

Day Phone_____ Alternate_____

Mother/Parent 1 (of patient under 18)

First Name_____ Middle_____

Last_____ SSN_____

Phone_____ Birthdate_____

Street _____ Apt/Bldg/Lot_____

City_____ State_____ Zip_____

E-Mail_____ Decline E-Mail☐

Father/Parent 2 (of patient under 18)

First Name_____ Middle_____

Last_____ Suffix____ SSN_____

Phone_____ Birthdate_____

Street _____ Apt/Bldg/Lot_____

City_____ State_____ Zip_____

E-Mail_____ Decline E-Mail☐

Emergency Contact Information

First Name_____ Middle _____Last_____ Relationship_____

Street _____City_____State_____Zip_____

Birthdate _____Home Phone _____Cell _____Work_____

(1) I understand that I am responsible for charges not covered or reimbursed by the above agents. I agree, in the event of non-payment, to assume the cost of the interest, collection and legal action (if required). (2) We are required by applicable federal and state law to maintain the privacy of your medical information. Our Notice of Privacy Practices document informs you of our notice at any time. (3) My right to payment for all pharmaceuticals, procedures, tests, medical equipment rentals, supplies and nursing/physician services including major medical benefits are hereby assigned to PPHC, PLLC This assignment covers any and all benefits under Medicare, other government sponsored programs, private insurance and any other health plans. I acknowledge this document as a legally binding assignment to collect my benefits as payment of claims for services. In the event my insurance carrier does not accept Assignment of Benefits, or if payments are made directly to me or my representative, I will insure such payment to PPHC, PLLC .

	Print Name	***Sign Name*** *(Signature Required)*	***Relationship to Patient***	***Date***
Patient				
Responsible Party (Of Patient Under 18 Or HealthCare POA)				

A copy of this authorization and assignment shall be considered as valid as the original.

New Patient Health History Form

Name: _____ Date of Birth: _____ Email: _____

Local Pharmacy:_____ Mail order Pharmacy: _____

Reason for your visit today:_____

Previous/current physicians: _____

Personal Medical History -Please mark **hat applies to you (currently or in the past)**

- ❑Allergies
- ❑Anemia
- ❑Anxiety
- ❑Arthritis (Type_____)
- ❑Asthma
- ❑Atrial Fibrillation
- ❑Enlarged Prostate (BPH)
- ❑Blood Clots/Clotting Disorder
- ❑Cancer (Type _____)
- ❑COPD/Emphysema
- ❑Coronary Artery Disease/Stents
- ❑Depression
- ❑Diabetes (Type 1 or 2)
- ❑High
- ❑GERD
- ❑Head
- ❑Heart
- ❑Hepatitis/Liver Disease
- ❑High Blood Pressure
- ❑Irritable Bowel
- ❑Heart Attack
- ❑Osteoporosis
- ❑Kidney Disease
- ❑Seizures
- ❑Stroke
- ❑Thyroid disease
- ❑Parkinson's Disease
- ❑Sleep Apnea
- ❑Substance Abuse
- ❑Tuberculosis
- ❑Dementia
- ❑HIV/AIDS
- ❑Fibromyalgia
- ❑Lupus

Women Only:

- ❑Abnormal PAP smear
- #_____ of Pregnancies
- #_____ of Children
- Last Menstrual Period _____

Other Medical Problems (not listed above) _____

_____

_____

Medication List - Please list currently prescribed medications and any supplements.

Medication Name	Dosage	How often?	30/90 day RX?	Refills needed?

Allergies - Please describe any allergic reactions to medications, foods, or the environment.

_____

_____

_____

REVIEW OF SYSTEMS ✔ CHECK ALL THAT APPLY

CONSTITUTION	CARDIOVASCULAR	SKIN
Activity change	Chest pain	Color change
Appetite change	Leg swelling	Pallor
Chills	Palpitations	Rash
Diaphoresis	**Gastrointestinal**	Wound
Fatigue	Abdominal distention	**ALLERGY/IMMUNO**
Fever	Abdominal pain	Environmental allergies
Unexpected weight change	Anal bleeding	Food allergies
HEAD, EAR, NOSE & THROAT	Blood in stool	Immunocompromised
Congestion	Constipation	**NEUROLOGICAL**
Dental problem	Diarrhea	Dizziness
Drooling	Nausea	Facial asymmetry
Ear discharge	Rectal pain	Headaches
Ear pain	Vomiting	Light-headedness
Facial swelling	**ENDOCRINE**	Numbness
Hearing loss	Cold intolerance	Seizures
Mouth sores	Heat intolerance	Speech difficulty
Nosebleeds	Polydipsia	Syncope
Postnasal drip	Polyphagia	Tremors
Rhinorrhea	Polyuria	Weakness
Sinus pressure	**Genitourinary**	**HEMATOLOGIC**
Sneezing	Difficulty urinating	Adenopathy
Sore throat	Dysuria	Bruises/bleeds easily
Tinnitus	Enuresis	**PSYCHIATRIC**
Trouble swallowing	Flank pain	Agitation
Voice change	Frequency	Behavior problem
EYES	Genital sore	Confusion
Eye discharge	Hematuria	Decreased concentration
Eye itching	Penile discharge	Dysphoric mood
Eye pain	Penile pain	Hallucinations
Eye redness	Penile swelling	Hyperactive
Photophobia	Scrotal swelling	Nervous/anxious
Visual disturbance	Testicular pain	Self-injury
RESPIRATORY	Urgency	Sleep disturbance
Apnea	Urine decreased	Suicidal ideas
Chest tightness	**MUSCULAR**	
Choking	Arthralgias	
Cough	Back pain	
Shortness of breath	Gait problems	
Stridor	Joint swelling	
Wheezing	Myalgias	
	Neck pain	
	Neck stiffness	

Patient Name: _____ DOB: _____

OTHER HEALTH ISSUES

SEXUAL ACTIVITY	Sexually involved currently? Y N *(If no sexual history, please continue to Exercise)*	
Sexual partner(s) is/are/have been: ❑ Male ❑ Female		
Birth control method: ❑ None ❑ Condom ❑ Pill/Ring/Patch/Inj/IUD ❑ Vasectomy		
EXERCISE	Do you exercise regularly? Y N *(If you answered no, please move to Sleep)*	
What kind of exercise?	***Duration:*** How long (min.): _____ How often: _____	
SLEEP	How many hours, on average, do you sleep at night *(or during the day, if working night shift)*?	
DIET	How would you rate your diet? ❑ Good ❑ Fair ❑ Poor	Would you like advice on your diet? Y N
SAFETY	Do you use a bike helmet? Y N	Do you use seat belts consistently? Y N
Working smoke detector in home? Y N		If you have guns at home, are they locked up? Y N
Is violence at home a concern for you? Y N		Have you completed an Advance Directive for Health Care (ADHC), Living Will, or Physical Orders for Life Sustaining Therapy (POLST)? Y N

OTHER PROVIDERS/SPECIALISTS

SPECIALIST	NAME	LAST VISIT
Cardiology		
Gastroenterologist (GI)		
OB/GYN		
Neurology		
Pulmonary		
Other:_____		
Other:_____		

ADDITIONAL INFORMATION

Have you traveled outside of the country in the last 30 days? Y N	If yes, where?
Have you served in the military? Y N	If yes, how long and what branch?
Were you deployed? Y N	If yes, where?

Please indicate if you would like Dr. Gina Whritenour, DNP, FNP-C of Palmetto Primary Healthcare, PLLC to be your Primary Care provider: _____Yes _____ No

Patient Name: _____ DOB: _____

Name: _____ **Date of Birth:** _____

Surgical History- If additional space is needed, please use back of sheet

Type of Surgery (example: hysterectomy)	**Date (year)**

Health Maintenance – Please bring a copy of your immunizations to your appointment.

	Date	**Results**
Colonoscopy		
Mammogram (women only)		
PAP smear (women only)		
DEXA (Bone density)		

Social History- What is your occupation? _____

Marital Status: ❑Married ❑Single ❑Divorced ❑Widowed ❑Life Partner

Who do you live with? _____

Tobacco Use ❑Current User ❑Never User ❑Former User
Type Used: _____ Amount per day: _____
# of Years used:_____ Quit Year _____

Alcohol Use ❑Current User ❑Never User ❑Former User
Type of alcohol: _____ How much per week:_____

Drug Use/Substance Abuse ❑Current User ❑Never User ❑Former User

Family History- Please indicate your family history in the boxes below
❑ Please check here if adopted (no family history available)

Biological Family Member	**Deceased?**	**List any medical problems (with age at diagnosis if known)**
Mother/Parent 1		
Father/Parent 2		
Sister(s)		
Brother (s)		
Daughter(s)		Ages:
Son(s)		Ages:
Maternal Grandmother		
Maternal Grandfather		
Paternal Grandmother		
Paternal Grandfather		
Other relations		

HIPPA

Authorization for Use and/or Disclosure of Protected Health Information for Palmetto Primary Healthcare, PLLC

I authorize the use and/or disclosure of my protected health information, as set forth below. I understand that this authorization is voluntary. I understand that, if the persons or organizations I authorize below are not health care providers, they may further disclose the protected health information and it may no longer be protected by federal health information privacy laws. This authorization will remain in place until a notice of change is provided in writing.
Protected Health Information to Be Used and/or Disclosed:
I authorize Palmetto Primary Healthcare, PLLC to discuss medical information regarding my care, test results, appointments and/or billing information with someone other than myself?
Yes□ No□

If yes, I authorize Palmetto Primary Healthcare, PLLC to disclose my protected health information to the following individuals, who may be contacted directly by Palmetto Primary Healthcare, PLLC:

Full Name: _____ Phone Number: _____ Relationship to Patient: _____

Full Name: _____ Phone Number: _____ Relationship to Patient: _____

Full Name: _____ Phone Number: _____ Relationship to Patient: _____

Please be advised that any person not referred to on this list will not be given any information related to your care, including billing information. You may change, restrict, or expand this listing at any time. You are not required to list any name if you do not so choose.

Patient's Signature: _____

Printed Patient Name: _____
Date: _____

If this authorization is signed by a personal representative on behalf of the patient, complete the following:
Personal Representative's Name:_____
Relationship to Patient:_____

Office Use Only:
Recorded by:_____ Date:_____

Controlled Substance Agreement

Patient Name: _____ DOB: _____

Narcotic pain medications are useful for short-term pain or cancer pain and to help dying patients with pain. There is little evidence that long-term use of narcotic pain medications helps chronic non-cancer pain and in fact could worsen it by leading to inactivity. Side effects of narcotic pain medication include but are not limited to: drowsiness, dizziness, constipation, nausea, confusion, respiratory depression, and death. I may also become psychologically or physically addicted to these medications. I understand my prescriber may choose alternative treatment options and it may be necessary to gradually decrease the amount of medication I am taking. To ensure that the medications are used in a safe manner, I agree to the following:

1. **I am responsible for my controlled substance medications.**
   a. I will take the medication only as prescribed.
   b. Prescriptions/medication will not be replaced if it is lost, misplaced/stolen or if I use it up sooner than prescribed.
   c. I agree to not share, sell, or otherwise permit others, including my family and friends, to have access to these medications.
   d. I will not participate in the diversion of my medications for illegal use.
   e. I understand I cannot drive while taking these medications or engage in activities that put me at risk.
2. **As a condition to receiving controlled substances, I understand my prescriber may require me to:**
   a. Pursue non-medication pain management therapies such as physical therapy or cognitive behavioral therapy or non-opioid medications. If I fail to do so, this agreement may be terminated.
   b. Obtain an opioid reversal medication, such as naloxone.
   c. Submit drug screens.
3. **I understand that prescriptions for controlled substance medications:**
   a. Will be provided only at regular office visits. I will not page my prescriber/health care providers to request a refill nor will I call them at home. Prescriptions will be sent electronically unless a technology issue prevents this.
   b. Will not be provided if I miss an appointment.
   c. Will not be provided if I run out of the medication early. I am responsible for taking the medication as it is prescribed and for keeping track of the amount remaining.
   d. May take up to 72 hours to process.
4. **This agreement will be terminated for:**
   a. Hostile behavior towards staff, attempting to refill prescriptions early, or too frequently
   b. Altering, forging, or attempting to get medications in an illegal manner; these type actions will be reported to the proper authority
   c. When deemed to be in the best interest as determined by my prescriber
   d. If I am arrested or incarcerated related to legal or illegal drugs
   e. Saving up medications or taking more than prescribed
   f. Failure to give a urine sample when requested or presence of unapproved drugs or lack of expected drugs in urine
5. Should my prescription medication or dosage need to be changed prior to my due date, all unused medications must be brought to our office for disposal.
6. I understand the prescription of controlled substances is under the supervision of many government agencies and adherence to regulations is my responsibility. If the responsible legal authorities have questions concerning your treatment, all confidentiality is waived and these authorities may be given full access to our records of controlled substance administration.
7. I give my prescriber permission to discuss all diagnostic and treatment details with dispensing pharmacies or other healthcare professionals for the purpose of maintaining accountability
8. I will not hold my prescriber liable if I am involved in an accident while taking the controlled substance they have prescribed
9. **FOR FEMALES:** I understand that if I become pregnant, or I suspect that I may be pregnant, I will notify the staff of the office. I further accept that any medication may cause harm to my embryo/fetus/baby and hold the office and all staff harmless for any injuries to the embryo/fetus/baby.
10. I will only accept a prescription from Palmetto Primary Healthcare, PLLC, and I will not request or accept controlled substance medication from any other prescriber, healthcare provider, or individual. The only exception is if the medication is prescribed while I am admitted to the hospital.
11. I will select and ONLY use one pharmacy to fill my controlled medication prescriptions. My pharmacy is _____

I have been fully informed regarding my treatment with the medications listed above as well as the reason for this agreement. I will receive a copy of this agreement and the original will be kept in my medical record at my prescribers' office.

Patient Signature: _____ Date: _____
Prescriber Signature: _____ Date: _____

Notice of Privacy Practices

Palmetto Primary Healthcare, PLLC

4850 Fayetteville Rd. Suite G

Lumberton, NC 28358

This notice describes how medical information about you may be used and disclosed, and how you can access this information.
Please review it carefully.

Notice Effective December 1, 2022

Our Pledge Regarding Health Information

Palmetto Primary Healthcare, PLLC, including all of its enterprises, locations, and affiliated providers, ("PPHC") takes the protection of your personal information seriously, and we are committed to protecting health information about you. Protected Health Information is information that may identify you and that relates to your past, present, or future physical or mental health or condition; the provision of health care products and services to you; or the payment for such services. In certain circumstances, pursuant to this Notice, patient authorization, or applicable laws and regulations, protected health information can be used by PPHC or disclosed to other parties. Below are categories describing these uses and disclosures, along with some examples to help you better understand each category.

This Notice of Privacy Practices ("Notice") is given to you by a PPHC provider to describe the ways in which we may use and disclose your protected health information and to notify you of your rights with respect to protected health information in our possession. This Notice applies to the PPHC and individuals or entities described in this Notice.

PPHC is required by law to maintain the privacy of your protected health information, to provide individuals with Notice of our legal duties and privacy practices with respect to protected health information, and to abide by the terms described in this Notice.

PPHC's Obligations

We are committed to:

- Making sure that health information that identifies you is kept private.
- Providing you with this Notice.
- Following the terms of the Notice that is currently in effect.
- Notifying you, after management's review, if we are unable to agree to a requested restriction on how your information is used or disclosed.
- Accommodating reasonable requests for communications of your health information in a particular manner or to a location other than your permanent address.
- Obtaining your written authorization to disclose your health information for reasons other than those listed above and required by law.
- Notifying you following a breach of your protected health information if it is determined that a breach has occurred.

How We May Use Your Health Information

For Treatment. We may use and disclose your health information to provide, coordinate or manage your medical treatment or related services. This medical information may be disclosed to providers, interns, nurses, technicians, volunteers, students, and others involved in your care. We may also share your medical information with health care providers and their staff outside PPHC, such as pharmacies and your other physicians. We may use and disclose health information to tell you about or recommend different ways to treat you. For example, if we are treating you for a broken hip, we may need to know if you have diabetes. The provider may need to

tell a dietician if you have diabetes so that we can arrange for appropriate meals. Different PPHC departments also may access your health information in order to coordinate services that you will need such as prescriptions, lab work and X-rays. We also may disclose your health information to other providers such as home health providers or physicians who may be involved in your medical care after you leave PPHC.

For Payment. We may use and disclose your health information to bill and collect payment for treatment and services
that you receive from us or from other health care providers. For example, a bill may be sent to you or to your insurance company. The bill will contain information that identifies you, as well as your diagnosis and procedures and supplies used in the course of treatment so your insurance company can provide payment. Your health plan or insurance company may also need information about a treatment you are going to receive to obtain prior approval or to determine whether they will cover the treatment.

In certain situations, you may request that we not send information about your treatment to your health plan or insurance company. See instructions for requesting a restriction under *Your Health Information Rights*.

For Health Care Operations. We may use and disclose health information about you for PPHC's health care operations. These uses and disclosures are necessary to run PPHC and to monitor the quality of care our patients receive.

For example, your health information may be disclosed to members of the medical staff, risk management or quality improvement personnel, and
others to:

- Evaluate the performance of our staff;
- Assess the quality of care and outcomes in your case and similar cases;
- Provide training to our staff;
- Learn how to improve our facilities and services; and
- Determine how we can make improvements in the care and services we provide.

To Individuals Involved in Your Care or Payment for Your Care. We may share information about your care or condition with an authorized representative, a family member, or another person identified by you or who is involved in your care or payment for your care. If you do not want information about you released to those involved in your care or payment for your care, see instructions for requesting a restriction under *Your Health Information Rights.*

Other Disclosures. Incidental disclosures of your health information may take place in the health care setting and are allowed by law.

<u>How We May Disclose Your Health Information Outside
of PPHC without Your Authorization</u>

Business Associates. We may share your protected health information with outside companies that perform services for us such as accreditation, legal, computer, or auditing services. These outside companies are called "Business Associates" and are required by HIPAA and by contract to keep your medical information confidential.

To You or Your Personal Representative. We may disclose your protected health information to you, or a representative appointed
by you or designated by applicable law.

When Required or Permitted by Law. We may disclose health information about you when required or permitted to do so by federal, state or local laws.

Judicial and Administrative Proceedings. We may disclose your health information to respond to a court or administrative order, subpoena, discovery request or other lawful process in accordance with applicable law.

Law Enforcement. We also may disclose information about you to law enforcement in certain circumstances, such as to report violent injuries, to provide certain information about persons involved in motor vehicle accidents, to report suspected criminal conduct committed at PPHC, to locate a suspect, fugitive, victim or missing person, or concerning an incapacitated victim of a crime. PPHC will adhere to state laws that require the reporting of certain information and that limit the information that can be disclosed to law enforcement in certain instances.

For Public Health Risks. We may disclose your information for the following public health activities:

- To prevent or control disease, injury or disability.
- To report births, deaths, and certain injuries or illnesses.
- To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.
- To report reactions to medications or problems with products.
- To notify you of recalls of products you may be using.
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.
- To make laboratory reports required by state law.

For Health Oversight Activities. We may disclose health information to a health oversight agency for oversight activities authorized by law such as investigations, inspections, audits, surveys and licensing. Examples of such agencies include organizations that ensure the quality or safety of the care we provide and agencies that accredit our hospital. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Abuse and Neglect. Subject to certain limitations, PPHC may disclose your protected health information to an appropriate government authority that is authorized by law to receive reports of abuse or neglect if we reasonably believe you are a victim of abuse or neglect.

To Avert a Serious Threat to Health and Safety. We may disclose health information about you to avert a serious threat to your health or safety or that of any other person or the public.

To Coroners, Medical Examiners and Funeral Directors. We may disclose health information to funeral directors, medical examiners or coroners to enable them to carry out their lawful duties.

For Organ and Tissue Donation. If you are an organ or tissue donor, your health information may be shared with organ procurement organizations, tissue banks and eye banks and upon request to the person or entity that you designated to be the recipient, as necessary to facilitate organ or tissue donation and transplantation.

For Research. We may use and disclose your health information for research purposes when a Institutional Review Board has reviewed and approved the research proposal. We also may disclose health information about you to people preparing to conduct a research project (for example, to help them look for patients with specific medical needs), so long as the health information they review does not leave PPHC. All research projects involving patients' medical information must be approved through a special review process to protect patient confidentiality. A researcher may have access to information that identifies you only through the special review process, or with your written permission. In addition, researchers may contact patients regarding their interest in participating in certain research studies. Researchers may only contact you if they have been given approval to do so by the special review process. You will only become a part of one of these research projects if you agree to do so and sign a consent form. Mental health information that identifies you will only be disclosed to researchers when you have given permission for us to do so.

For National Security and Intelligence Activities. We may disclose your health information to federal officials for intelligence, counterintelligence, and national security activities authorized by law. Your medical information may be disclosed to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state, or conduct special investigations.

Disaster Relief. Your protected health information may be disclosed to an entity assisting in a disaster relief effort so your family can be notified about your condition, status, and location.

Active Duty Military Personnel and Veterans. If you are an active duty member of the armed forces or Coast Guard, we must give certain information about you to your commanding officer or other command authority so that your fitness for duty or for a particular mission may be determined, to comply with military health surveillance requirements, or for an activity necessary to carry out the military mission. We also may release health information about foreign military personnel to the appropriate foreign military authority. We may use and disclose to components of the Department of Veterans Affairs health information about you to determine whether you are eligible for certain benefits.

Treatment Alternatives. We may use and disclose health information to tell you about or recommend different ways to treat you.

Inmates. We may disclose your health information to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.

Workers' Compensation. If you seek treatment for a work-related illness or injury, we may disclose your health information about your treatment for such illness or injury in order to comply with laws and regulations related to Workers' Compensation or similar programs. These programs provide benefits for work-related injuries or illness.

To Health Information Exchange Organizations. To the extent permitted or required by law, we may disclose your health information to one or more health information exchange networks ("HIEs") in which PPHC participates and the other participants in the HIE for treatment, payment, and permitted health care operations. An HIE is an electronic system that allows other health care providers treating you to access and share your medical information if they also participate in the HIE. This access and sharing can help your providers or other providers outside of PPHC to more quickly provide you with appropriate care because they know about your previous health conditions and treatments. North Carolina's HIE, NC HealthConnex, permits certain individuals to opt out of participation. However, submitting an Opt Out Form does not mean your data will not be submitted by PPHC to NC HealthConnex. North Carolina providers who receive Medicaid or state funds for the provision of health care services are required by law to send data pertaining to health care services that are funded by the State. If your health care services are not paid for by the State and you do not want your data to be disclosed to NC HealthConnex, you may request that PPHC restrict the submission of your data. For more information regarding NC HealthConnex's opt-out process, please visit https://hiea.nc.gov/patients/your-choices.

Uses and Disclosures that Require Your Authorization.

Other uses and disclosures of health information not covered by this Notice, including disclosures for research projects that have not been reviewed and approved by PPHC's Institutional Review Board, uses or disclosures for marketing purposes, or disclosures of your information in exchange for some form of payment, may be made only if you authorize the use or disclosure in writing. If you authorize us to use or disclose health information about you, you may revoke that authorization, in writing, at any time by submitting a written request to PPHC's Privacy Officer at any time. If you revoke your authorization, we will no longer use or disclose health information about you for the purposes that you previously had authorized in writing. However, we are unable to take back any disclosures we have already made with your permission, and we are required to retain our records of the care that we provided to you. In addition, other types of information may have greater protection under federal or state law, such as certain drug and alcohol information, HIV/AIDS and other communicable disease information, genetic information, mental health information, or information about developmental disabilities. For this type of information, we may be required to get your written permission before disclosing it to others; we may seek that permission if permitted by law. If you have any questions about this, contact PPHC's Privacy Officer, whose contact information is provided at the end of this Notice.

Your Health Information Rights

You have the following rights with respect to your protected health information. All requests must be submitted in writing to PPHC's Privacy Officer. Please contact the Privacy Officer for additional information regarding any of these rights. The contact information for the Privacy Officer can be found at the end of this Notice. Request a restriction on uses and disclosures of your health information. Except where we are required by law to disclose the information, you have the right to ask us not to use or disclose certain health information we maintain about you. PPHC is not required to agree to your request, with the exceptions described below. If we do agree, we will comply with your request. To request restrictions, complete a Request for Restriction of Health Information form. In your request, you must tell us:

(1) what information you want to limit;

(2) whether you want to limit our use, disclosure, or both; and

(3) to whom you want the limits to apply, for example, disclosures to your spouse.

Request to not disclose health information to your health plan or insurance company. You may request that we not disclose your health information to your health plan or insurance company for some or all of the services you receive during a visit to any PPHC location. If you pay in advance the charges in full for those services you don't wish disclosed, we generally are required to agree to your request unless the disclosure is for treatment purposes or is required by law. "In full" means the amount we charge for the service, not your copay, coinsurance, or deductible responsibility when your health plan or insurer pays for your care. There may be limitations on our ability to agree to your request, including, for example, if you want to restrict disclosure of only some of a group of items or services provided in a single visit where the group of services is typically bundled together for payment. Please note that once information about a service has been submitted to your health plan or insurance company, we cannot agree to your request. If you think you may wish to restrict the disclosure of your health information for a certain service, please let us know prior to the visit in writing.

Request to inspect and obtain a copy of your health record. Your health information is contained in records that are the physical property of PPHC. With certain exceptions, you have the right to request to inspect and obtain a copy of your medical information that may be used to make decisions about your care. You may request that we send an electronic copy to any person or entity you designate in writing, and we will do so if you clearly identify the person or entity and where to send the information. To inspect, receive a copy, or have us send a copy of your health information to someone else, submit a request in writing. We may charge a fee for the costs associated with providing you or a third party paper or electronic copies of your records. There are certain situations in which we are not required to comply with your request. Under these circumstances, we will respond to you in writing, stating why we will not grant your request and describing any rights you may have to request a review of our denial. PPHC maintains original health information records for the periods required by law and then destroys such records pursuant to its records destruction policy and applicable law.

Request to correct or amend information in your health record. If you feel that health information we have about you is incorrect or incomplete, you may ask us to amend the information by submitting a request in writing that provides a reason supporting your request. Please be specific about the information that you believe is incorrect or incomplete. If we determine that the health information is incorrect or incomplete, we will revise your record. If we deny your request, you will be notified in writing, and you may submit a written statement of disagreement and ask that it be included in your medical record.

Request confidential communications. You have the right to request that we communicate with you about health information in a certain way or at a location other than your home address. For example, you may ask that we contact you by mail rather than by telephone, or at work rather than at home. We will accommodate all reasonable requests and will not ask you the reason for your request. It is your responsibility to make sure we have your correct address and contact information. Your request must specify how or where you wish to be contacted.

Receive a listing of how your information has been shared, with some exceptions under the law. You have the right to request a listing of certain types of disclosures we have made of your health information for a specified time period. Your request must be submitted in writing to the and must state the time period for which you want this listing, such as six (6) months or two (2) calendar years. The first accounting you request in any 12-month period will be free. For additional accountings that you request within a 12-month period, we may charge you for the costs of providing the accounting. We will notify you of the cost in advance so that you can choose whether to withdraw or modify your request.

Receive a paper copy of this notice. You have the right to receive a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time during our operational hours.

Right to be notified of a breach. If we determine that a breach of your unsecured protected health information has occurred, we will notify you in writing about the breach and tell you what we have done or intend to do to mitigate the damage (if any) caused by the breach, and about what steps you should take to protect yourself from potential harm resulting from the breach.

Changes to this Notice. PPHC reserves the right to change the terms of this Notice and to make the new provisions effective for all protected health information it maintains about you. Revised Notices will be made available to you by posting them in our facilities and posting them on our Website, and upon your request we will provide you with a copy of the most recent version of our Notice. The Notice will contain the effective date at the top of the first page.

Complaints. You will not be penalized or retaliated against for filing a complaint. If you believe your rights have been violated, you may file a complaint with PPHC or with the United States Secretary of the Department of Health and Human Services. To submit a complaint to the Department of Health and Human Services, you must contact the Office for Civil Rights of the Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue, SW, Room 509F, Washington, D.C. 20201. To file a complaint with PPHC, submit your complaint to our Privacy Officer in writing.

Non-Discrimination. PPHC
does not discriminate on the basis of race, ethnicity, color, religion, sex, sexual orientation, gender identity, national origin, age, disability, genetic information, veteran status, or any other protected characteristic under applicable law.

Contact Information. If you have any complaints or questions about information in this document, you may contact:

Privacy Officer, PPHC

4850 Fayetteville Rd.

Suite G

Lumberton, NC 28358

By Signing below, I am indicating that I have read, understood, and been offered a copy of the Notice of Privacy Practices for Palmetto Primary Healthcare, PLLC

Patient's Signature: _____

Printed Patient Name: _____

Date: _____

If this authorization is signed by a personal representative on behalf of the patient, complete the following:
Personal Representative's Name:_____
Relationship to Patient:_____

FINANCIAL POLICY (Pg. 1)

Insurance Verification

At each visit, the patient must provide an active insurance card with current, correct information. Without proof of insurance, the patient may be rescheduled. Palmetto Primary Healthcare, PLLC makes it a priority to verify proof of a patient's insurance, however, it is the patient's responsibility to know his/her benefits for all medical services including wellness benefits prior to time of service. Any balance left unpaid by insurance remains the patient's responsibility.

We participate in most insurance plans. If you are not insured by a plan we have a contract with, payment is due in full at time of service.

Insurance Processing

Please understand that payment of your bill is considered part of your services/treatment. The patient and/or guarantor are responsible for charges incurred. It is a courtesy for our office to file your insurance; however, you are responsible for your co-pay or deductible which the insurance company is not liable for on the day of your visit. Insurance companies require Palmetto Primary Healthcare, PLLC to collect co-pays, deductibles or co-insurance amounts at the time of service. Because more insurance companies are issuing policies with very high deductibles, we will need to collect deductibles that have not been met at time of service. ***It is your responsibility to call your insurance company prior to being seen to see if you have met your deductible.*** We have formulated a fee amount that we have tried to make as close as possible to the allowable amount that will be covered by your insurance company. Anything over paid or under paid will either be credited or billed to you accordingly. If you do not call your insurance company prior to being seen we will assume that you have not met your deductible and payment of the allowable amount is due at time of service.

Self-Pay/Cash Pay

Palmetto Primary Healthcare, PLLC contracts with most insurance companies for patient services. The patient remains financially responsible for all their care, but the remaining balance for services rendered to the patient will not be billed to the patient until payment is received from the insurance company(s), the insurance company denies the claim, or the insurance company unreasonably fails to pay in a timely manner. A statement will be sent to the patient or responsible party. The billed amount on the statement is due when the first statement is received.

Outstanding Balances

Patients will be asked to settle any outstanding balances with Palmetto Primary Healthcare, PLLC before their next appointment. You may pay any outstanding balances at any time in our office or over the phone with credit card. Patients with outstanding balances may be declined treatment or triaged for non-emergency until the balance is resolved. Patient balances which are not resolved in a timely manner will be sent to an outside collection agency. If the balance is transferred to an outside agency, the patient will be responsible for paying any additional collection fees associated with the collection of the patient balance.

FINANCIAL POLICY (Pg. 2)

Patient Accounts with outstanding balances and no payment activity will be forwarded to a collection agency at the patient's expense. In addition to any outstanding balances, the Patient or the Patient's representative who signs the Acknowledgement of Notice of Financial Policy agrees to pay addition collection processing fees of 30% of the original balance plus all costs associated with such collection activity, including interest incurred and reasonable attorney and court fees.

24-Hour Cancellation Policy

Palmetto Primary Healthcare, PLLC requires a 24-hours cancellation notice for all appointments as a courtesy to our staff and other patients needing medical attention. Please make sure to contact our office promptly if you need to cancel/reschedule your appointment. If we do not receive adequate notice, a $25 no-show fee will be applied to your balance after the second failure. THIS FEE WILL NOT BE BILLED TO YOUR INSURANCE. We understand that emergencies can occur, and we will take that into account before applying any fees to your balance.

Payment can be paid in person or mailed to:

Palmetto Primary Healthcare, PLLC

4850 Fayetteville Rd., Suite G

Lumberton, NC 28358

Non-covered services – It is virtually impossible for us to have knowledge of what services each insurance plan covers. ***Knowing your insurance benefits is your responsibility.*** Any questions you may have regarding those benefits or dispute of any services not covered should be directed to your insurance company.

Laboratory Fees:

If your insurance company requires a specific laboratory, it is your responsibility to notify us of this prior to your appointment. Otherwise, we will send your specimen to a cooperating laboratory. If there are any costs related to the biopsy, pathology, cultures, or other lab work that your insurance carrier does not cover you will be responsible for those costs. You may receive a separate bill from the laboratory that processes your specimen. Questions regarding laboratory bills should be directed to the specific laboratory indicated on your bill. You may be required to provide your insurance information to the laboratory for claims.

FINANCIAL POLICY (Pg. 3)

ACKNOWLEDGEMENT OF NOTICE OF FINANCIAL POLICY

Patient Responsibility for Medical Service Charges

Assignment of Benefits – I, the undersigned, realize that all medical and surgical charges incurred are my responsibility and payable by me regardless of what my insurance pays. I hereby authorize and direct my insurance carrier(s) to pay directly to Palmetto Primary Healthcare, PLLC and/or its providers any benefits due under my insurance plan. I agree to pay the balance of expenses not paid under this plan, including deductibles and co-payments

I, the undersigned, have read and understand Palmetto Primary Healthcare, PLLC financial policy and agree to the terms. I authorize the release of any medical information necessary to process the payment of treatment to my insurance company, and request payment of benefits to Palmetto Primary Healthcare, PLLC. I acknowledge that I am financially responsible for payment whether or not covered by insurance. I additionally agree that I will be responsible for payment in full of any co-pay at the time services are rendered as well as any deductible that may exist for said services.

I further agree that, should I be sent to collections for failure to pay for services rendered, I will be responsible for all reasonable fees and costs associated with collections, including reasonable attorney fees and court costs, and agree to pay interest on any charges sent to collections at the rate permissible by law.

I have read and understand the financial policy and agree to abide by it.

Patient's Signature: _____

Printed Patient Name: _____

Date: _____

If this authorization is signed by a personal representative on behalf of the patient, complete the following:
Personal Representative's Name:_____
Relationship to Patient:_____

Palmetto Primary Healthcare PLLC

For patients who pay any invoice, either by mail or in person, using a check as a form of payment, the following policy is in effect:

When you provide a check as payment you authorize us to use information from your check to process a one-time Electronic Funds Transfer (EFT) or a draft drawn from your account, or to process the payment as a check transaction. When we use information from your check to make an EFT, funds may be withdrawn from your account as soon as the same day we receive your payment, and you will not receive your check back from your financial institution. If your payment is returned unpaid, you authorize the collection of your payment and a return fee of $____35.00____ by EFT(s) or draft(s) drawn from your account.

By signing below, I attest that I understand the statement above and am aware of Palmetto Primary Healthcare, PLLC's returned check policy which pertains to any payments I make using a check. I have had the ability to ask questions regarding this policy.

_____ _____

Patient Name Date

_____

Patient Signature

_____

Signature of Financially Responsible Person (if different from patient)

CONSENT TO ELECTRONIC/DIGITAL COMMUNICATION (EMAIL, VOICE AND/OR OR TEXT MESSAGE) USAGE FOR APPOINTMENT REMINDERS AND HEALTHCARE NOTIFICATIONS

Patients in our practice are contacted via email, voice and/or text messaging with appointment reminders, to obtain feedback on your experience with our healthcare team, and to provide general health reminders or information. Palmetto Primary Healthcare, PLLC does not charge for this service, but standard text messaging rates may apply as provided in the patient's wireless plan (contact wireless carrier for pricing details).

If at any time I, the patient, provide an email or phone number at which I may be contacted, I consent to receiving appointment reminders and other healthcare communications or information via email, voice and/or text message from Palmetto Primary Healthcare, PLLC via the email and/or phone numbers or any email and/or phone number that I choose to forward or transfer my incoming electronic communication. I understand that this request to receive emails, voice and/or text messages will apply to all future electronic/digital communication from Palmetto Primary Healthcare, PLLC unless I request a change in writing.

Y___N___ I Agree to text communications.
Phone number for text:_____
(Message and Data rates may apply, check with your carrier)

Y___N___ I Agree to email communication.
Email address:_____

You must select "Yes" for email if you wish to view your medical records online

Y___N___ I Agree to voice mail/answering machine communication.
Phone number:_____

I have read and understand the **ELECTRONIC/DIGITAL COMMUNICATION** policy above.

Patient's Signature: _____
or Responsible Party Signature _____

Printed Patient Name: _____

Date: _____

Palmetto Primary Healthcare, PLLC

Patient Portal (Patient Fusion) – Consent Form

Palmetto Primary Healthcare, PLLC offers secure viewing and communication as a service to patients who wish to view parts of their records and communicate with our staff. Secure messaging can be a valuable communications tool but has certain risks. In order to manage these risks, we need to impose some conditions of participation. This form is intended to show that you have been informed of these risks and the conditions of participation, and that you accept the risks and agree to the conditions of participation.

How the Secure Patient Portal Works:
A secure web portal is a type of webpage that uses encryption to keep unauthorized persons from reading communications, information, or attachments. Secure messages and information can only be read by someone who knows the right password or pass-phrase to log in to the portal site. Because the connection channel between your computer and the website uses secure sockets layer technology you can read or view information on your computer, but it is still encrypted in transmission between the website and your computer.

Protecting Your Private Health Information and Risks:
This method of communication and viewing prevents unauthorized parties from being able to access or read messages while they are in transmission. However, keeping messages secure depends on two additional factors:

- the secure message must reach the correct email address, and
- only the correct individual (or someone authorized by that individual) must be able to have access to the message.

Only you can make sure these two factors are present. It is imperative that our practice has your correct e-mail address and that you inform us of any changes to your e-mail address. You are responsible for protecting yourself from unauthorized individuals learning your password. If you think someone has learned your password, you should promptly go to the website and change it.
Types of Online Communication/Messaging:
Online communications should never be used for emergency communications or urgent requests. If you have an emergency or an urgent request, contact our office by telephone.

Patient Acknowledgement and Agreement:
I acknowledge that I have read and fully understand this consent form and the Policies and Procedures regarding the Patient Portal. I understand the risks associated with online communications between my provider's office and me, and consent to the conditions outlined herein. In addition, I agree to follow the instructions set forth herein, as well as any other instructions that my physician's office may impose to communicate with patients via online communications.
I understand and agree with the information that I have been provided and am aware I may refuse to disclose my email address.

Patient Name _____Date of Birth_____
Patient or Responsible Party Signature _____
Date ___ /___ /_____

Patient or Responsible Party's **Email Address** for use with Patient Portal:_____

PLEASE NOTE: If you do not complete this form, you will not have access to view your medical records online. However, you may request to complete this form at a later time.

Consent for video or other recording for security and/or Health Care Operations

To ensure patient safety and the safety of our staff, Palmetto Primary Healthcare, PLLC maintains a highly secured facility. Security cameras are place throughout the facility where legally permissible. By entering the facility, I consent to video, digital or audio recordings, and/or images of me being recorded for patient care, security purposes and/or the practice's/clinic's healthcare operations purposes (e.g., quality improvement activities). I understand that the practice/clinic retains the ownership rights to the images and/or recordings. I will be allowed to request access to any copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that any recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used outside the facility without a specific written authorization from me or my legal representative unless otherwise permitted or required by law.

I have read and understand the **Security recording** policy above and consent to the conditions stated:

Patient's Signature: _____
or Responsible Party Signature _____
Printed Patient Name: _____

Date: _____

Consent to retrieve prescription history.

Prior to prescribing controlled substances, Palmetto Primary Healtcare, PLLC will review a patient's medication history using the Prescription Drug Monitoring Program of North Carolina and neighboring states. Additionally, medication history may be obtained from current or previous providers to ensure the most comprehensive medication use.

By signing below, I give consent to retrieve prescription history, if available, when request is triggered during scheduling an appointment or ordering a medication, and reconciliation of current medications in my electronic health record (EHR)

Patient's Signature: _____
or Responsible Party Signature _____

Printed Patient Name: _____

Date: _____

GENERAL PATIENT CONSENT FOR CARE AND TREATMENT

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your healthcare provider, we encourage you to ask questions.

I voluntarily request a health care provider or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I, the patient, certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Patient's Signature: _____
Printed Patient Name: _____
Date: _____

If this authorization is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name:_____
Relationship to Patient:_____

Office Use Only:
Recorded
by:_____Date:_____