PATIENT RESPONSIBILITY FORM

We at CPG Aynor Family Medicine would like to thank you for the opportunity to provide care to you and your family. Essential to providing this care are responsibilities you have as a patient. Please initial each of the following to indicate you have read and fully understand the following terms:

_________ Please call our office during normal operating hours to schedule an appointment for routine visits. If your condition is life-threatening, please call 911 immediately. For other urgent needs, we offer same day sick appointments.

_________ For all appointments, please bring a current insurance card and photo ID and all current medications.

_________ For prescription refills, please call your pharmacy. They will contact us via fax with the necessary information. Allow 24-48 hours for all refills. No refills will be called in after normal operating hours or on weekends.

_________ If you should need to cancel your appointment, please provide our office with 24 hours notice. Multiple no-shows can lead to dismissal and/or cancellation fees.

_________ We participate with multiple insurance companies, but not all. It is your responsibility to know your benefits, who your insurance company participates with, and what they will cover. Unpaid charges are the obligation of the patient to pay. Any balances not paid after 90 days will be turned over to a collection agency. The patient/guarantor is responsible for all collection fees, legal fees, or court costs incurred by pursuing the debt.

_________ All copays, deductibles, and payments for non-covered services are due at check-in. Unpaid balances will also be collected at this time. If a copayment or balance cannot be paid, the office has the right to reschedule routine appointments until the debt can be paid. We accept cash, check, credit and debit card.

_________ A returned check fee of $30.00 will be charged.

We understand sometimes financial problems can occur. During these times, we are willing to work with you to set up alternative payment arrangements if necessary.

_____________________________________    _______________
Patient/Guarantor Signature                            Date
# Patient Information

<table>
<thead>
<tr>
<th>Patient name</th>
<th>DOB</th>
<th>Age</th>
<th>Gender – Circle one</th>
<th>Today’s Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Male</td>
<td>Female</td>
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</table>

<table>
<thead>
<tr>
<th>Address</th>
<th>Home phone</th>
<th>Cell phone</th>
<th>e-mail</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>City/State/Zip</th>
<th>SS#</th>
<th>Marital Status - Circle one</th>
<th></th>
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<tr>
<td></td>
<td></td>
<td>S</td>
<td>M</td>
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<table>
<thead>
<tr>
<th>Emergency Contact</th>
<th>Relationship</th>
<th>Phone #</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>(H)</td>
<td>(C)</td>
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</table>

# Patient Employment Information

<table>
<thead>
<tr>
<th>Employer</th>
<th>Contact name</th>
<th>Work number</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Address</th>
<th>City/State/Zip</th>
</tr>
</thead>
</table>

# Guarantor Insurance Information

<table>
<thead>
<tr>
<th>Primary Insurance</th>
<th>Employer</th>
<th>Secondary Insurance</th>
<th>Employer</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Policy #</th>
<th>Group #</th>
<th>Policy #</th>
<th>Group #</th>
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</table>

<table>
<thead>
<tr>
<th>Insured Name</th>
<th>Insured Name</th>
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<table>
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<tr>
<th>Address</th>
<th>City/State/Zip</th>
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<table>
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<tr>
<th>Insured DOB</th>
<th>Insured SS#</th>
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<table>
<thead>
<tr>
<th>Guarantor Employment Information</th>
<th></th>
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</table>

<table>
<thead>
<tr>
<th>Employer</th>
<th>Contact name</th>
<th>Work number</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Address</th>
<th>City/State/Zip</th>
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</thead>
</table>

# Additional Information

<table>
<thead>
<tr>
<th>Parent/Guardian Name</th>
<th>Day Phone</th>
</tr>
</thead>
</table>

# Referral Information

| How did you hear about us? |  |

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**Consent for Healthcare and Release of Medical Information**

I voluntarily consent to treatment at this facility by its physicians and staff. No guarantees have been made to me about the results of treatments or examination by staff at this practice. I consent to the use and disclosure of my protected health information for treatment, payment and healthcare operations. I have read this form and had the opportunity to ask questions.

**Financial Responsibility and Assignment of Insurance Benefits**

I authorize Aynor Family Medicine to bill my insurance company using the information I have provided to this office for payment to their MEDICAL FACILITY. I assign payment for the unpaid charges for certain physician services to Aynor Family Medicine. I understand I am responsible for any health insurance deductible, co-pay, and co-insurance payments. I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any medical or any other information about me to be released to the Social Security Administration or its intermediaries or carriers and any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf.

Signature of Patient or Authorized Person: __________________________ Date: __________

**Acknowledgement of Receipt of Notice of Privacy Practices**

I have received a copy of the Notice of Privacy Practices. I am aware that the Notice may be changed at any time and that I may request a copy of the revised notice by contacting the Office Manager.

Signature of Patient or Authorized Person: __________________________ Date: __________

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☐ Patient refused to sign
☐ Patient refused to sign after receiving the Notice. Explanation provided that signature only documents that the Notice was received.
☐ Unable to provide NPP due to an emergency situation and the patient was not able to sign
☐ Patient refused copy of NPP but understands a copy is available upon request.

Signature of: __________________________ Date: __________

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FOR STAFF USE ONLY

☐ Patient refused to sign
☐ Patient refused to sign after receiving the Notice. Explanation provided that signature only documents that the Notice was received.
☐ Unable to provide NPP due to an emergency situation and the patient was not able to sign
☐ Patient refused copy of NPP but understands a copy is available upon request.

Signature of: __________________________ Date: __________
**MEDICAL HISTORY**

NAME: ____________________________  SS#: ____________________________  DATE: ____________________

ADDRESS: _____________________________________________________________  OCCUPATION: ____________________________

PHONE: (HOME) _________________________  WORK: _________________________  AGE: ________  DATE OF BIRTH: _____________

**DRUG ALLERGIES:**

(Include Herbals, Vitamins, Minerals)

___________________________________  ______________________________________________________________________________

___________________________________  ______________________________________________________________________________

___________________________________  ______________________________________________________________________________

___________________________________  ______________________________________________________________________________

**FAMILY HISTORY:**

<table>
<thead>
<tr>
<th>MEDICAL PROBLEM</th>
<th>Father</th>
<th>Mother</th>
<th>Father’s Parents</th>
<th>Mother’s Parents</th>
<th>Brothers/Sisters</th>
<th>Children</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart disease</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>High blood pressure</td>
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<tr>
<td>Stroke</td>
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<tr>
<td>Cancer</td>
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<tr>
<td>Glaucoma</td>
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<tr>
<td>Diabetes</td>
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<tr>
<td>Seizures</td>
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<tr>
<td>Kidney disease</td>
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<tr>
<td>Thyroid disease</td>
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<tr>
<td>Mental illness</td>
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<tr>
<td>Other:</td>
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**PAST SURGERIES:**

________________________________________________________________________________________________

________________________________________________________________________________________________

**MEDICAL HISTORY:**

___ Colon problems  ___ Rheumatic fever

___ Eye problems    ___ Bowel irregularity  Do you smoke? _________ If so, how much? ____________

___ Headaches       ___ Gall bladder disease  Do you drink alcohol? ________ If so, how much? ____________

___ Heart disease   ___ Prostate disease

___ High blood pressure  ___ Bladder/urinary tract problems

___ Chest pain  ___ Venereal disease

___ Dizziness/fainting  ___ Vascular disease  ___ AIDS

___ Hepatitis/Liver disease  ___ Anemia

___ Lung disease  ___ Arthritis

___ Asthma  ___ Anxiety/Nervousness

___ Bronchitis/pneumonia  ___ Depression

___ Allergies/Hayfever  ___ Diabetes (Sugar)

**WOMEN ONLY:**

___ Menstrual Irregularity

Number of Pregnancies: _______  Number of Deliveries: _______

Other: ____________________________

______________________________

ADVANCE DIRECTIVES?  YES _____  NO _____

INF REQUESTED?  YES _____  NO _____

COPIES IN CHART?  YES _____  NO _____
**PHYSICAL EXAM**

**NAME:** ___________________________________________  **DOB:** ____________________  **DATE:** ____________________

**VITAL SIGNS**

<table>
<thead>
<tr>
<th>Weight</th>
<th>Height</th>
<th>Temperature</th>
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<thead>
<tr>
<th>BP</th>
<th>Pulse</th>
<th>Respiratory</th>
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**Patient History**

**Physical**

Past

________________________________________________________________________________________________________________________________

________________________________________________________________________________________________________________________________

________________________________________________________________________________________________________________________________

Present

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________________________________________________________________________________________________________________________________

________________________________________________________________________________________________________________________________

**Social**

Past

________________________________________________________________________________________________________________________________

________________________________________________________________________________________________________________________________

________________________________________________________________________________________________________________________________

Present

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________________________________________________________________________________________________________________________________

________________________________________________________________________________________________________________________________

**REVIEW OF SYSTEMS**

**Neurologic** | **GI** | **Cardiovascular**

<table>
<thead>
<tr>
<th>GU</th>
<th>Cerebrovascular</th>
<th>Musculoskeletal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Peripheral</td>
<td>Dermatologic</td>
<td>Hematologic</td>
</tr>
</tbody>
</table>

**Gynecological** | **Respiratory**

**NOTES**

**Skin**

**HEENT**

**Neck/Thyroid**

**Veins/Carotid**

**Chest**

**Breast**

**Lungs**

**Heart**

**Abdomen**

**Genital**

**Rectal**

**Extremities**

Neurologic

**LABS/TEST ORDERED:**

________________________________________________________________________________________________________________________________

________________________________________________________________________________________________________________________________

________________________________________________________________________________________________________________________________

**IMPRESSION**

________________________________________________________________________________________________________________________________

________________________________________________________________________________________________________________________________

________________________________________________________________________________________________________________________________

**PLAN**

________________________________________________________________________________________________________________________________

________________________________________________________________________________________________________________________________

________________________________________________________________________________________________________________________________
Compound Authorization for Release of Information

Name of Patient ___________________________ Date of Birth __________________

Aynor Family Practice ______________________ is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient’s instructions.

Entity to Receive Information.
Check each person/entity that you approve to receive information.

- Voice Mail
- Give information to employer
- Give information to school
- Spouse
- Parent (provide name) ________________
- Other (provide name) __________________
- Support Group (provide name) __________

Description of information to be released.
Check each that can be given to person/entity on the left in the same section.

- Results of lab tests/x-rays
- Other
- Appointment absentee information
- Family billing information
- Financial
- Medical as follows: ____________________
- Family Billing Information
- Financial
- Medical as follows: ____________________
- Financial
- Medical as follows
- Demographic Information

Rights of the Patient
I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending a written notification to Aynor Family Practice. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.

Signature of Patient or Personal Representative ________________________________
Date __________________

Description of Personal Representative’s Authority (attach necessary documentation) ____________________________________________________________
CONWAY PHYSICIANS GROUP

NOTICE OF PRIVACY PRACTICES

This Notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

The privacy of your health information is important to us.

This Notice describes how we may use and disclose your protected health information to provide treatment, obtain payment and conduct health care operations and for other purposes permitted or required by law. It also describes your rights concerning your protected health information. “Protected health information” is information about you, including demographic information that may identify you and relates to your past, present or future physical or mental health or condition and related health care services.

We are required by law to follow the practices described in this Notice. We may change the terms of this Notice at any time. The new Notice will be effective for all protected health information we maintain at that time including health information we created or received before we made the changes. You may obtain a copy of our Notice of Privacy Practices at any time by calling our office or requesting one at your next appointment.

Uses and Disclosures of Health Information

Treatment: We will use and disclose your health information to provide, coordinate and manage health care and related services for you. For example we will disclose information to a specialist to whom you have been referred to ensure the provider has enough information to diagnose and/or treat you. We may also disclose information to a laboratory that, at our request, becomes involved in your treatment.

Payment: We may use and disclose your information to obtain payment for services we provided to you. For example we will send the necessary information to your health or dental insurance company to obtain payment for the treatment provided.

Healthcare Operations: We will use and disclose your health information to conduct the business activities of this office. These activities include, but are not limited to, quality assessment and improvement activities, review of the performance and qualifications of employees, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

We may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting room when we are ready to begin your treatment. We may call to remind you of an appointment and if you are not available we may leave a message on your voice mail or with another member of your household.

We will share your protected health information with business associates that perform specific functions for our practice such as billing. When a business arrangement of this type requires the use of your information, we will have a written contract with the third party to protect the privacy of your protected health information.

Others Involved in Your Health Care: We must disclose your health information to you as described in the Patient Rights section of this Notice. We may disclose your health information to a family member or other person to the extent necessary to help with your health care or with payment for your health care, but only if you agree. If we determine it is in your best interest based on our professional judgement or experience with common practices, we may allow another person to pick up filled prescriptions, medical supplies, x-rays or other forms of health information.

We may use or disclose protected health information to notify or assist in notifying a family member, a personal representative or any other person responsible for your care of your location, your general condition or death. If you are present prior to the use or disclosure of your protected health information, we will provide you with the opportunity to object to such uses or disclosures. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family members or others involved in your health care.

Emergencies: In the event of your incapacity or in emergency circumstances, we may use or disclose your protected health information to treat you.

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization: Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization, at any time, in writing, except to the extent that an action has already been taken in reliance on the authorization.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Consent, Authorization or Opportunity to Object

We may use or disclose your protected health information in the following situations without your consent or authorization. These situations include:

Required By Law: We may use or disclose your protected health information to the extent that law requires the use or disclosure. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law.

We must make disclosures to you and, when required, to the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of the Privacy Rule, 45 CFR 164.500 et seq.

Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. Additionally, we may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.
Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of the practice, and (6) medical emergency (not on the Practice’s premises) and it is likely that a crime has occurred.

Military Activity and National Security: When the appropriate conditions apply, we may disclose, to military authorities, protected health information of individuals who are Armed Forces personnel. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities including for the provision of protective services to the President or others legally authorized.

Workers’ Compensation: we may disclose your protected health information as authorized to comply with workers’ compensation laws and other similarly legislated programs.

Inmates: We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

Your Rights
Your rights with respect to your protected health information and how you may exercise those rights are outlined below.

You have a right to obtain a copy and/or inspect your health information: Health information includes treatment records, billing records and any other records used by us to make decision about your treatment. You may obtain a form from our office to request access. A reasonable cost-based fee will be charged for expenses such as staff time, copies and postage. Contact us as indicated at the end of this Notice to obtain information about our fees or if you have any questions about your access.

You have a right to request a restriction on the use and disclosure of your protected health information: You may ask us not to use or disclose some part of your protected health information for the purposes of treatment, payment or operations. You may also request that we not disclose some part of your information to family and others who may be involved in your care or for notification purposes as otherwise described in this Notice. We are not required to agree to the restrictions but if we do, we are obligated to abide by the agreement except in cases of emergency. You may request a restriction by sending your request in writing to our Privacy Contact.

You may have the right to request an amendment to your protected health information. You may request that we amend protected health information about you. Your request must be in writing with an explanation as to why the information should be amended. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You may have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures made by our Business Associates or us. It excludes disclosures for treatment, payment or healthcare operations as described in this Notice of Privacy Practices, to you, to family members or friends involved in your care, for notification purposes or as a result of an authorization signed by you. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003 for up to the previous 6 years. You may request a shorter timeframe. The right to receive this information is subject to certain exceptions, restrictions and limitations. If you request an accounting more than once in a 12 month period, we will charge you a reasonable cost-based fee for responding to the additional request.

You may have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

The Adult Consent Act & Disclosure of Health Information to Designated Individuals (S.117): “DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHEN?” NO ___ YES (WHEN).

You may revoke or modify this specific authorization and the revocation or modification must be in writing.

This law defines treatment as “the broad range of emergency, outpatient, intermediate, and inpatient services and care that may be extended to a patient to diagnose and treat a human disease, ailment, defect, abnormality, or complaint, whether of physical or mental origin. Treatment includes, but is not limited to, psychiatric, psychological, substance abuse, and counseling services.”

The provider who discloses this information in good faith in accordance with the designation, the provider will be immune from civil and clinical liability, and disciplinary sanctions. While we assume most hospitals already have forms which comply with this law, we are encouraged to review all of your forms and add this required language if needed. This law becomes effective January 1, 2014.

Questions and Complaints
If you have any questions, concerns or want more information about our privacy practices please contact us using the information below.

If you are concerned that we may have violated your privacy rights or you disagree with a decision we have made regarding your access to your health information or any other request you have made in the exercise of your rights, you may send your complaint to us using the information below. You may also submit a written complaint to the Secretary of Health and Human Services. Contact us for the address of the Department of Health and Human Services.

We support your right to the privacy of your health information and we will not retaliate against you in any way for filing a complaint.

Contact our office:

Contact Office or Official Warren C. Ratley, MBA, FACMPE, President

Phone 843-234-5139 Fax 843-234-6822

Address 300 Singleton Ridge Road

PO. Box 829

Conway, SC 29528-0829

This notice was published and becomes effective on January 1, 2009.