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PATIENT DEMOGRAPHICS

Last _____ **Suffix** ◯ **II** ◯ **III** ◯ **IV** ◯ **Jr** ◯ **Sr**

First _____ **Middle Initial** _____

Previous Name_____ **What name would you like us to use?** _____

Mailing Address _____ **City** _____ **State** _____ **Zip** _____

Home Phone: _____ **Cell/Mobile Phone:** _____ **Work Phone:** _____

Email: _____

Date of Birth (mo/day/yr) _____ / _____ / _____ **Social Sec #** _____ - _____ - _____

Sex at Birth - ◯ Male ◯ Female

Gender Identity (18 and older) - ◯ Male ◯ Female ◯ Transgender Male-to-Female
◯ Transgender Female-to-Male ◯ Genderqueer ◯ Additional Gender ◯ Choose not to disclose

Sexual Orientation (18 and older) - ◯ Straight or heterosexual ◯ Lesbian/Gay ◯ Bisexual ◯ Do not know
◯ Other ◯ Choose not to disclose

Responsible Party Name *(person financially responsible for any patient balances):* _____

Relationship to patient: _____ **Responsible Party Date of Birth** (mo/day/yr) ___/___ / _____

Mailing Address _____ **City** _____ **State** _____ **Zip** _____

Responsible Party Phone: _____

Emergency Contact _____ **Phone Number** _____ **Relationship** _____

Marital Status - ◯ Single ◯ Married ◯ Legally Separated ◯ Divorced ◯ Widowed ◯ Life Partner

Primary Language - ◯ English ◯ Spanish ◯ Portuguese ◯ Other _____

Translator/Interpreter Needed - ◯ Yes ◯ No. **If yes, which type?** ◯ Hearing Impaired ◯ Language

Race - ◯ African American/Black ◯ White ◯ Asian ◯ American Indian/Alaska Native ◯ Native Hawaiian
◯ Other Pacific Islander ◯ More than one race (If more than one, list all) _____

Ethnicity - ◯ Hispanic/Latino ◯ Not Hispanic/Latino

Student Status - ◯ Full-time student ◯ Part-time student ◯ Not a student

Employment Status - ◯ Full-time ◯ Part-time ◯ Self-employed ◯ Retired ◯ Unemployed

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◯ **I do not have insurance and would like to apply for your sliding fee Please** *complete a sliding fee application*

If uninsured, have you applied for Medicaid or Health Care Marketplace Insurance? ◯ Yes ◯ No

Medicaid – when? _____ **Marketplace – when?** _____

Family income data is needed by the government for us to get federal funding. Your personal information is not shared with anyone. We do provide the information collectively as an organization. We appreciate your assistance. Please select the range that best suits your family's income. **# In Family** _____

◯ **$0 - $10,000** ◯ **$10,001 - $20,000** ◯ **$20,001 - $30,000**

◯ **$30,001 - $40,000** ◯ **$40,001 - $50,000** ◯ **$50,001 - $60,000**

◯ **$60,001 - $70,000** ◯ **$70,001 - $80,000** ◯ **$80,001 or greater**

◯ **Choose not to disclose**

Residential Address (if mailing address is a PO BOX)

Street Address _____ **City** _____ **State** _____ **Zip** _____

DEMOGRAPHIC INFORMATION

(This information is for demographic purposes only.)

Military Status - ◯ Current Active Military ◯ Veteran ◯ Never served in the military

Do you rent or own your home/apartment? - ◯ Yes ◯ No **If no, are you staying:** ◯ in a shelter

◯ with friends/family ◯ transitional housing ◯ street ◯ other: _____

Have you or your family established a temporary home to work in agriculture? ◯ Yes ◯ No

In the past 2 years, have you or a member of your family worked in agriculture on a seasonal basis? ◯ Yes ◯ No

Voter Registration - ◯ Already registered ◯ Would like to register ◯ Not interested in registering

How did you hear about Little River Medical Center? - ◯ Billboard ◯ Newspaper ◯ Family/Friend ◯ Radio

◯ Hospital ◯ Other physician practice ◯ Television ◯ Phone book ◯ Online/website ◯ Social Media

◯ Community Event ◯ Other

Would you like to use Little River Medical Center as your primary pharmacy? ◯ Yes ◯ No

Preferred Pharmacy Name: _____

Pharmacy Address: _____

Pharmacy Phone Number: _____

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Patient Name: _____ Date: _____

Primary Reason for this dental appointment: _____ Examination _____ Emergency _____ Consultation

DENTAL HISTORY

	Yes	No	Description
Do you have a specific dental problem? (if yes, please describe)			
Do you have dental examinations on a routine basis?			Last visit:
Do you think you have active decay or gum disease?			
Do you brush and floss on a routine basis?			
Do your gums ever bleed?			
Do you like your smile? Why/why not?			
Does food catch between your teeth? Any loose teeth?			
Do you want to keep your remaining teeth?			
Do you ever have clicking, popping, or discomfort in the jaw joint? Do you brux or grind?			
Have your past experiences in a dental office always been positive?			
Do you smoke or chew? Any sores or growths in your mouth?			
Name of previous dentist (optional)			
Date of last full mouth x-rays (16 small films or panoramic)			

MEDICAL HISTORY

	Yes	No	Description
Are you under a physician's care now? Why?			
Have you ever been hospitalized or had a major operation? (If yes, please describe)			
Have you ever had a serious injury to your head or neck? (If yes, please describe)			
Are you taking any medications, polls, drugs, or herbal products? (If yes, please list)			
Are you on a special diet? (if yes, please describe)			
Are you allergic to any medications or substances? (If yes, please check)			◯ Aspirin ◯ Penicillin ◯ Codeine ◯ Acrylic ◯ Metal ◯ Latex ◯ Other:
Do you wish to talk to the dentist privately about any problems?			
*Women (please mark)			◯ Pregnant/trying to get pregnant ◯ Nursing ◯ Taking oral contraceptives

To the best of my knowledge, all the preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and staff at the next appointment without fail.

Patient/Guardian Signature: _____ Date: _____

Reviewed by Doctor: _____ Date: _____ BP: _____

History Review and Significant Findings: _____
_____
_____

MEDICAL UPDATES

I have read my MEDICAL HISTORY dated _____ and confirm that it adequately states past and present conditions.

Date	Exceptions		Patient Signature	BP	Reviewed by (Dr)
		_____ None			
		_____ None			
		_____ None			
		_____ None			
		_____ None			
		_____ None			
		_____ None			

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Authorization for Release of Medical Information

I authorize LRMC to release any medical information pertinent to payment of medical expenses incurred by me to the insurance carriers names below or its intermediaries, carriers, agents, or billing agents. I permit a copy of the authorization to be used in place of the original request for payment of medical insurance benefits either to myself or to the party who accepts assignments.

Insurance Carrier	Date	Policy Number
Insurance Carrier	Date	Policy Number

Cardholder's Name: _____ SSN: _____ Relationship to Patient: _____

Cardholder's DOB: _____ Phone Number: _____ Cell Phone: _____

ASSIGNMENT OF INSURANCE BENEFITS

I hereby assign by rights under the above-named policy of insurance to Little River Medical Center including but not limited to major medical and dental insurance, hospital benefits, sick benefits, or injured benefits. In the event a third party is deemed liable for any medical conditions, I assign my rights under an insured such as auto insurance workman's compensation insurance and/or minimum medical hospital or disability payments commonly referred to as "PIP" pursuant to Section 56-11*110 S.C. Code of Laws, 1976, as amended, and the proceeded of all claims resulting from the liability of the third party payable by any person, employer, insurance company to or for me up to the full amounts of the medical/dental charges incurred. In addition, I further warrant and represent that any insurance assigned is valid insurance and in effect.

PERSONAL LIABILITY

I expressly understand that I am personally responsible for the entire amounts of medical/dental/behavioral health expenses incurred by me for care and treatment, either inpatient or outpatient. Any payment received by Little River Medical Center as a result of the above Authorization for Release of Medical Information and Assignments of Insurance Benefits will be credit towards y accounts, and I will be personally liable for any and all remaining balance on any Little River Medical Center's Medical, Behavioral Health or Dental Accounts.

INSURANCE OR HOUSEHOLD INCOME INFORMATION UPDATE

I will always inform the office of Little River Medical Center of all insurance changes and household income changes or updates. Failure to do so may result in (me) _____ paying for services rendered in full.

CONSENT FOR MEDICAL/DENTAL/BEHAVIORAL/PHARMACY CARE AND TREATMENT

I authorize Little River Medical Center to render medical/dental care and treatment as they deem appropriate under the directions of my primary care physician/dentist and of such associates, partners or designees as may be selected to perform such treatment. I recognize during the course of treatment, conditions may arise that necessitate additional procedures or services, and I further authorize and request that my physician/dentist and/or associates, partners, assistants, or designees as may be selected by him to perform such procedures, services are in their best professional judgement.

For the purpose of advancing medical knowledge, I consent to the admittance of medical students, translators, and observers in accordance with ordinary partners of this medical facility ◯ Yes ◯ No I authorize pharmaceutical manufactures and their auditors to access my pharmacy records as a part of my participation in their patient assistance program, if I participate in such program. I understand that this information may include medication and protected health information. (_____) initials

I, _____, give consent to disclose (a) ◯ all my personal healthcare information (PHI) or (b) ◯ only the following PHI _____

During my visit to Little River Medical Center (LRMC) to the following individuals and these individuals may pick up my medication from LRMC Pharmacy and receive PHI results by telephone from LRMC:

Name	Relationship	Phone Number	Cell Phone Number

I, _____, Legal Guardian of Minor Child, _____, give permission for LRMC to disclose PHI about the above Minor Child during (a) ◯ healthcare visit, and/or (b) ◯ on the telephone to the following individuals, who may also pick up the minor child's medication from the LRMC Pharmacy:

Name	Relationship	Phone Number	Cell Phone Number

This authorization shall be in force and effective until: _____ at which time this authorization to disclose this information expires. No guarantees or assurances have been made or given by anyone as to the results that may be obtained by any treatment or procedures rendered to me. By signing below, the undersigned certifies that the foregoing paragraphs have been read in full and understood by the undersigned and all information is true.

Signature of Patient/Guardian: _____ Date: _____

Witness: _____ Date: _____

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Little River Medical Center Payment Policy

For us to continue to serve you and your family's health care needs, we ask that you abide by our payment policy.

1. Payment is due and payable at the time service is rendered. Any other arrangements must be made with the business office manager, or designee, prior to being seen.

2. Little River Medical Center reserves the right to control appointments until financial arrangements have been made.

3. Little River Medical Center will file insurance claims with only certain insurance carriers. The front office will discuss your policy with you at the time of your first visit. Depending upon your insurance company, a co-payment and/or percentage may be required at check in.

4. Little River Medical Center is not responsible for follow-up with insurance carriers. When payment from the insurance carrier has not been received within 45 days of filing, the responsible party will then receive a statement that payment will be expected within 15 days.

5. Patients qualifying for our sliding fee program are responsible for payment in full for services or rates that have been set on a sliding scale.

6. Payment is expected at time of service.
   What method of payment(s) will be used? ◯ Cash ◯ Check ◯ Master Card ◯ VISA

The undersigned hereby acknowledges to have read and agrees with the above payment policy of Little River Medical Center.

Signature Date

Printed Name

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About Our Notice of Privacy Practices

We are committed to protecting your personal health information in compliance with the law. The attached Notice of Privacy Practices states:

- our obligations under the law with respect to your personal health information.
- how we may use and disclose the health information that v/e keep about you.
- your rights relating to your personal health information.
- our rights to change our Notice of Privacy Practices.
- how to file a complaint if you believe your privacy rights have been violated.
- the conditions that apply to uses and disclosures not described in this Notice.
- the person to contact for further information about our privacy practices.

We are required by law to give you a copy of this notice and to obtain our written acknowledgment that you have received a copy of this notice.

Patient Acknowledgment of Receipt

I,_____, hereby acknowledge that I have received a copy of the Notice of Privacy Practices.

_____

Patient Signature Date

_____

Patient Representative Signature (if applicable) Date

_____

Description of Legal Authority to Act on Behalf of the Patient

In lieu of patient signature, I,_____, a staff member of Little River Medical Center, stated that_____ has been given our current Notice of Privacy Practices.

Date:_____

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NOTICE OF PRIVACY PRACTICES

Effective Date Revised 10/7/2015

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY

If you have any questions about this Notice of Privacy Practices ('Notice'), please contact
Privacy Officer
Phone Number: 843-663-8002 or Fax: 843-663-8102
P. O. Box 547 Little River, SC 29566

Section A: Who Will Follow This Notice?

This Notice describes Little River Medical Center's (hereafter referred to as 'LRMC') Privacy Practices and that of

Any workforce member authorized to create medical information referred to as Protected Health Information (PHI) which may be used for purposes such as Treatment, Payment and Healthcare Operations These workforce members may include:

- All departments and units of LRMC.
- Any member of a volunteer group.
- All employees, staff and other LRMC personnel
- Any entity providing services under LRMC's direction and control will follow the terms of this notice. In addition, these entities, sites and locations may share medical information with each other for Treatment Payment or Hea1thcare Operational purposes described in this Notice.

Section B: Our Pledge Regarding Medical Information

We understand that medical Information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive at LRMC. We need this record to provide you with quality care and to comply with certain legal requirements. This Notice applies to all the records of your care generated or maintained by LRMC, whether made by LRMC personnel or your personal doctor/provider.

This Notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

We are required by law to:

- Make sure that medical information that identifies you is kept private.
- Give you this Notice of our legal duties and privacy practices with respect to medical information about you; and
- Follow the terms of the Notice that is currently in effect.

Section C: How We May Use and Disclose Medical Information About You

The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all the ways we are permitted to use and disclose information will fall within one of the categories.

- **Treatment.** We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, health care students, or other Provider personnel who are involved in taking care of you at LRMC. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. In addition, the doctor may need to tell the dietitian if you have diabetes so that we can arrange for appropriate meals. Different departments of LRMC abo may share medical information about you to coordinate different items, such as prescriptions, lab work and x-rays. We also may disclose medical information about you to people outside LRMC who may be involved in your medical care after you leave LRMC.

- **Payment.** We may use and disclose medical information about you so that the treatment and services you receive at LRMC may be billed and payment may be collected from you, an insurance company or a third party. For example, we may need to give your health plan information about a visit you received at our office so your health plan will pay us or reimburse you for the procedure. We may also tell your health plan about a prescribed treatment to obtain prior approval or to determine whether your plan will cover the treatment.

Healthcare Operations. We may use and disclose medical information about you for LRMC operations. These uses and disclosures are necessary to run our business and make sure that all of our patients receive quality care. For example, we may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine medical information about many LRMC patients to decide what additional services we should offer, what services are not needed, and whether certain new treatments are effective. We may also disclose information to doctors, nurses, technicians, health care students, and other LRMC personnel for review and learning purposes. We may also combine the medical information we have with medical information from other Providers to compare how we are doing and see where we can make improvements in the care and services we offer. We may remove information that identifies you from this set of medical information so others may use it to study health care and health care delivery without learning a patient's identity. In an effort to provide, coordinate, or manage your health related services and the health services to the LRMC community, we may use or share your personal and electronic health information through SCHlEX (South Carolina Health Information Exchange),other Health Information Exchange or other entities LRMC is under contract for services. Additionally, we may provide such information to pharmacy entities outside of LRMC who aid In providing pharmaceutical care to be you including the LRMC Mail Order Pharmacy program, contract pharmacies that are active partners with LRMC which can be found on the Office of Pharmacy Affairs 340B Database, and institutional prescription drug assistance programs. Your doctors and other health care providers will use and share your electronic health information with other doctors and health care providers involved in your care, through SCHlEX to provide, coordinate, or manage your health care and any related services.

- **Appointment Reminders**. We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or medical care at LRMC.
- **Treatment Alternatives.** We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.
- **Health-Related Benefits and Services**. We may use and disclose medical information to tell you about health-related benefits or services that may be of interest to you.
- **Fundraising Activities.** We may use Information about you to contact you to raise money for the LRMC and its operations. We may disclose information to a foundation related to the LRMC so that the foundation may contact you about raising money. We only would release contact information, such as your name, address and phone number and the dates you received treatment or services LRMC. If you do not want the us to contact you for fundraising efforts, you must notify us in writing, and you will be given the opportunity to 'Opt-out' of these communications.
- **Authorizations Required.** We will not use your protected health information for any purposes not specifically allowed by Federal or State laws or regulations without your written authorization, this includes uses of your PHI for marketing or sales activities.
- **Emergencies.** We may use or disclose your medical information if you need emergency treatment or if we are required by law to treat you but are unable to obtain your consent If this happens, we will try to obtain your consent as soon as we reasonably can after we treat you.
- **Psychotherapy Notes.** Psychotherapy notes are accorded strict protections under several laws and regulations. Therefore, we will disclosure psychotherapy notes only upon your written authorization with limited exceptions.
- **Communication Barriers.** We may use and disclose your health information if we are unable to obtain your consent because of substantial communication barriers, and we believe you would want us to treat you if we could communicate with you.
- **Individuals Involved in Your Care or Payment for Your Care.** We may release medical information about you to a friend or family member who is involved in your medical care and we may also give information to someone who helps pay for your care, unless you object in writing and ask us not to provide this information to specific individuals. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status, and location.
- **Research.** Under certain circumstances, we may use and disclose medical information about you for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another, for the same condition. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of medical information, trying to balance the research needs with patients need for privacy of their medical information. Before we use or disclose medical information for research, the project will have been approved through this research approval process, but we may, however, disclose medical 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 medical information they review does not leave LRMC. We will almost always generally ask for your specific permission if the researcher with have access to your name, address other information that reveals who you are, or will be involved in your care at LRMC.

- **As Required By Law**. We will disclose medical information about you when required to do so by federal state or local law.
- **To Avert a Serious Threat to Health or Safety**. We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat
- **E-mail Use.** E-mail will only be used following LRMC's current policies and practices and with your permission. The use of secured, encrypted e-mail is encouraged.

Section D: Special Situations

- **Organ and Tissue Donation.** If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.
- **Military and Veterans.** If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may also release medical Information about foreign military personnel to the appropriate foreign military authority.
- **Workers' Compensation.** We may release medical information about you for workers' compensation or similar programs.
- **Public Health Risks.** We may disclose medical Information about you for public health activities. These activities generally include the following:
  - to prevent or control disease, Injury or disability.
  - to report births and deaths;
  - to report child abuse or neglect.
  - to report reactions to medications or problems with products; to notify people of recalls of products they 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; and

To notify appropriate government authority if we believe a patient has been me victim or abuse. Neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

- **Health Oversight Activities.** We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include・ for example, audits investigations inspections, and licensure. These activities are necessary for the government to monitor the health care system government programs, and compliance with civil rights laws
- **Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute・ we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena discovery request, or other lawful process by someone else invoked in the dispute but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.
- **Law Enforcement.** We may release medical information if asked to do so by a law enforcement official:
  - in response to a court order, subpoena, warrant, summons, or similar process
  - to identify or locate a suspect, fugitive material witness, or missing person:
  - about the victim of a crime if, under certain limited circumstances, we are unable
  - to obtain the person's agreement about a death we believe may be the result of criminal conduct:
  - about criminal conduct at the Provider; and
  - in emergency circumstances, to report a crime, the locate on of the crime or victims, or the identity, description or location of the person who committed the crime.
- **Coroners, Medical Examiners and Funeral Directors.** We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients of the Provider to funeral directors as necessary to carry out their duties.
- **National Security and Intelligence Activities.** We may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.
- **Protective Services for the President and Others.** We may disclose medical information about you to authorized federal officials so they may provide protection to the President other authorized persons or foreign heads of state or conduct special investigations.
- **Inmates.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official. This release would be necessary for the institution to provide you with health care, to protect your health and safety or the health and safety of others, or for the safety and security of the correctional institution.

Section E: Your Rights Regarding Medical Information About You

You have the following rights regarding medical information we maintain about you:

- **Right to Access, Inspect and Copy.** You have the right to access, inspect and copy the medical information that may be used to make decisions about your care, with a few exceptions. Usually, this includes medical and billing records, but may not include psychotherapy notes. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.
- **We may deny your request to inspect and copy medical information in certain very limited circumstances.** If you are denied access to medical information, in some cases, you may request that the denial be reviewed. Another licensed health care professional chosen by the LRMC will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.
- **Right to Amend.** If you feel that medical information, we have about you is incorrect or incomplete you may ask us to amend the Information. You have the right to request an amendment for as long as the information Is kept by or for LRMC. In addition, you must provide a reason that supports your request.
- **We may deny your request for an amendment if it is not in writing or does not include a reason to support the request**. In addition, we may deny your request if you ask us to amend information that:
    - Was not created by us, unless the person or entity that created the information is no longer available to make the amendment,
    - Is not part of the medical information kept by or for the Provider,
    - Is not part of the information which you would be permitted to inspect and copy; or
    - Is accurate and complete.
- **Right to an Accounting of Disclosures.** You have the right to request an Account ng of Disclosures. This is a list of the disclosures we made of medical information about you. Your request must state a time which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the accounting (for example, on paper or electronically, if available). The first accounting you request within a 12 month period will be complimentary. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the medical information we use or disclose about you for payment or healthcare operations. You also have the right to request a limit on the medical Information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose Information about a surgery you had. In your request, you must tell us what Information you want to limit, whether you want to limit our use, disclosure or both, and to whom you want the limits to apply (for example, disclosures to your spouse). We are not required to agree to these types of request. We will not comply with any requests to restrict use or access of your medical information for treatment purposes.
    - You also have the right to restrict use and disclosure of your medical Information about a service or item for which you have paid out of pocket, for payment (Le. health plans) and operational (but not treatment) purposes if you have completely paid your bill for this Item or service. We will not accept your request for this type of restriction until you have completely paid your bill (zero balance) for this Item or service. We are not required to notify other healthcare providers of these restrictions, that is your responsibility.
    - **Right to Receive Notice of a Breach.** We are required to notify you by first class mail or by email (if you have indicated a preference to receive information by email), of any breaches of Unsecured Protected Health Information as soon as possible, but in any event, no later than 60 days following the discovery of the breach. "Unsecured Protected Health Information" is information that is not secured through the use of a technology or methodology identified by the Secretary of the U.S Department of Health and Human Services to render the Protected Health Information unusable, unreadable, and undecipherable to unauthorized users. The notice is required to include the following information·
        - a brief description of the breach, including the date of the breach and the date of its discovery if known; o a description of the type of Unsecured Protected Health Information involved in the breach.
        - steps you should take to protect yourself from potential harm resulting from the breach.
        - a brief description of actions we are taking to investigate the breach, mitigate losses, and protect against further breaches.
        - Contact information, including a toll-free telephone number, e-mail address, Web site or postal address to permit you to ask questions or obtain additional Information.

- **Right to Receive Notice of a Breach.** We are required to notify you by first class mail or by email (if you have indicated a preference to receive information by email), of any breaches of Unsecured Protected Health Information as soon as possible, but in any event, no later than 60 days following the discovery of the breach. "Unsecured Protected Health Information" is information that is not secured through the use of a technology or methodology identified by the Secretary of the U.S Department of Health and Human Services to render the Protected Health Information unusable, unreadable, and undecipherable to unauthorized users. The notice is required to include the following information·
    - a brief description of the breach, including the date of the breach and the date of its discovery if known; o a description of the type of Unsecured Protected Health Information involved in the breach.
    - steps you should take to protect yourself from potential harm resulting from the breach.
    - a brief description of actions we are taking to investigate the breach, mitigate losses, and protect against further breaches.
    - Contact information, including a toll-free telephone number, e-mail address, Web site or postal address to permit you to ask questions or obtain additional Information.

In the event the breach involves 10 or more patients whose contact information is out of date we will post a notice of the breach on the home page of our website or in a major print or broadcast media. If the breach involves more than 500 patients in the state or jurisdiction, we will send notices to prominent media outlets. If the breach involves more than 500 patients, we are required to immediately notify the Secretary. We also are required to submit an annual report to the Secretary of a breach that involved less than 500 patients during the year and will maintain a written log of breaches involving less than 500 patients.

- **Right to Request Confidential Communications.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or hard copy or email. We will not ask you the reason for your request. We will accommodate all reasonably requests. Your request must specify how or where you wish to be contacted.
- **Right to a Paper Copy of This Notice.** You have the right to a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy of this Notice. You may obtain a copy of this Notice at our website www.lrmcenter.com

To exercise the above rights, please contact the individual listed at the top of this Notice to obtain a copy of the relevant form you will need to complete to make your request.

Section F: Changes to This Notice

We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice. The Notice will contain on the first page, in the top right-hand corner, the effective date.

Section G: Complaints

If you believe your privacy rights have been violated, you may file a complaint with the LRMC by contacting the HIPAA Privacy Officer at 843-663-8002 or with the Secretary of the Department of Health and Human Services; http://ww.hhs.gov/ocr/privacy/hipaa/complain/index.hlml

To file a complaint with LRMC, contact the individual listed on the first page of this Notice. All complaints must be submitted in writing You will not be penalized for filing a complaint.

Section H: Other Uses of Medical Information

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

Section I: Organized Healthcare Arrangement

LRMC, the independent contractor members of its Medical Staff (including your physician), and other healthcare providers affiliated with the Provider have agreed, as permitted by law to share your health information among themselves for purposes of treatment· payment or health care operations. This enables us to better address your healthcare needs.

LRMC | LITTLE RIVER MEDICAL CENTER

Patient's Bill of Rights

Little River Medical Center has adopted the following "Patient's Bill of Rights." At Little River Medical Center, we uphold the following policies regarding the rights and responsibilities of our patients:

As a patient you have the right to understand and use these rights. If for any reason you do not understand or need help, the Center must provide assistance, including an interpreter.

As a patient you have the right to receive treatment without discrimination as to race, color, religion, sex, national origin, disability, sexual orientation, or source of payment.

As a patient you have the right to receive considerate and respectful care in a clean and safe environment free from unnecessary restraints.

As a patient you have the right to receive emergency care if you need it.

As a patient you have the right to be informed of the name and position of the doctor who will be in charge of your care in the hospital and the Center.

As a patient you have the right to receive complete information about your diagnosis, treatment and prognosis.

As a patient you have the right to receive all the information that you need to give informed consent for any proposed procedure or treatment. This information shall include the possible risks and benefits of the procedure or treatment.

As a patient you have the right to receive all the information you need to appoint someone you trust to make health care decisions for you if you lose the ability to decide for yourself. You can appoint a "health care agent or proxy" by using a Health Care Proxy form provided to you at the time of registration at the center. You can give the person you select as your health care agent as little or as much authority as you want. You can allow your agent to decide about all health care or only certain treatments. You may also give your agent instructions that your agent can follow.

As a patient you have the right to refuse treatment and be told what effect this may have on your health.

As a patient you have the right to refuse to take part in research. In deciding whether or not to participate, you have the right to a full explanation.

As a patient you have the right to privacy while in the Center and confidentiality of all information and records regarding your case.

As a patient you have the right to participate in all decisions about your treatment at the Center.

As a patient you have the right to review your medical records without charge and obtain a copy of your medical record for which the Center can charge a reasonable fee. You cannot be denied a copy solely because you cannot afford to pay.

As a patient you have the right to complain without fear or reprisals about the care and services you are receiving and to have the Center respond to you and if you request it, a written response.

_____

Signature of Patient/Guardian

_____

Date

_____

Printed Name