

We know you're busy. That's why Palmetto Health-USC Medical Group's physician practices are offering a way for you to manage your health care online.

We offer convenient and easy-to-use patient portals that allow you to:

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

Our portals are encrypted and password-protected, too, so health data remains secure.

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

OneChart

Select Palmetto Health-USC Medical Group practices.

MyHealth  
Physician

Former Palmetto Health Physician Practices provider portals.



Former USC Specialty Clinics provider portals.

MyHealth  
Palmetto Heart

Access Palmetto Heart's portal.

MyHealth  
Orthopedics

Former Palmetto Health Orthopedics providers' portal.

MyHealth  
Tuomey

Former Palmetto Health Tuomey Physician Practice providers' portal.

**Patient Information**

**Patient Information**

Patient Name (last, first, middle) \_\_\_\_\_

SSN \_\_\_\_\_ Birth Date \_\_\_\_\_ Gender  Male  Female Marital Status \_\_\_\_\_

Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Phone: Home \_\_\_\_\_ Cell \_\_\_\_\_ Work \_\_\_\_\_

Email \_\_\_\_\_

Employer \_\_\_\_\_

Race and Ethnicity \_\_\_\_\_ Primary Language \_\_\_\_\_

Do you have a Health care Power of Attorney?  Yes  No Are you an organ donor?  Yes  No

**Emergency Contact Information**

Name \_\_\_\_\_

Relationship to Patient \_\_\_\_\_ Phone \_\_\_\_\_

**Parent/Legal Guardian Information (as applicable)**

Name \_\_\_\_\_ Name \_\_\_\_\_

Address \_\_\_\_\_ Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

**Guarantor's Information (Financially Responsible Party)**

Check if patient is guarantor

Name \_\_\_\_\_ SSN \_\_\_\_\_ Birth Date \_\_\_\_\_

Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Phone \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

**Insured's Information**

Primary Insurance Company \_\_\_\_\_ Secondary Insurance Company \_\_\_\_\_

Insurance ID \_\_\_\_\_ Insurance ID \_\_\_\_\_

Group ID \_\_\_\_\_ Group ID \_\_\_\_\_

Name \_\_\_\_\_ Name \_\_\_\_\_

SSN \_\_\_\_\_ Birth Date \_\_\_\_\_ SSN \_\_\_\_\_ Birth Date \_\_\_\_\_

Phone \_\_\_\_\_ Phone \_\_\_\_\_

Relationship to Patient \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

**Release of Information**

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor. I understand that I am responsible for any amount not covered by my insurance. I request that payment of authorized Medicare benefits be made to my physicians.

\_\_\_\_\_  
Patient's Signature or Legally Qualified Representative      Patient/Guardian Print Name      Date/Time

\_\_\_\_\_  
Relation to Patient      Date/Time

\_\_\_\_\_  
Patient's Name

\_\_\_\_\_  
DOB

\_\_\_\_\_  
MRN

**It is the policy of Palmetto Health – USC Medical Group to provide the most efficient and reasonable health care services. Therefore, it is necessary for us to have a Financial Policy and Disclosure stating our requirements for payment for services provided to all patients.**

Patients are responsible for the payment of all services provided by Palmetto Health – USC Medical Group.

**Self-Pay Policy**

- If you are a self-pay patient, you will be required to pay for the office visit before services are rendered
- In addition, any remaining balance on your account after receiving treatment will be collected at discharge.

**Insurance Policy**

- If you are a patient with insurance, it is our policy to file for insurance as a courtesy to you, if we have accurate and complete insurance information.
- If a service is provided that is not covered by your insurance company, you will be the responsible party at the time of service.
- If we have not received a payment from your insurance company within sixty (60) days after the claim has been filed, you will be responsible for the balance due.
- Deductibles, co-payments, and coinsurance will be collected before services are rendered.
- In special cases, we may need your help in contacting your insurance company for the payment of your services.
- If you do not want PHUSCMG to file to your insurance, please inform the registration staff at check-in. Services not filed to your insurance will be considered self-pay, and payment is due at time of service.

**Past Due Balances**

- All over-due patient balances will be sent to collections.
- All accounts sent to collections will be charged a 20% collection fee in addition to the account balance.

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

- Providing us with current and updated information on yourself and your insurance company.
- Presenting an updated photo identification card and insurance card when changes are made.
- Making the appropriate payment at the time of service, whether it is a deductible, co-pay, coinsurance, or for the full amount if you are a Self-Pay Patient.

In order to provide the best medical care, we ask that you do not discuss your account balance or financial aspects with the physician(s) or medical team members. Please discuss any account information with the checkout associate or front desk members.

\_\_\_\_\_  
Patient's Signature or Legally Qualified Representative

\_\_\_\_\_  
Date/Time

\_\_\_\_\_  
Patient/Guardian Print Name

\_\_\_\_\_  
Relation to Patient

\_\_\_\_\_  
Palmetto Health-USC Medical Group Representative

\_\_\_\_\_  
Date/Time

## Joint Notice of Privacy Practices

Effective Date 10-3-2016

**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.**

At the Palmetto Health-USC Medical Group (“Medical Group”), protecting the privacy of our patients is important. We understand that medical information about you is personal. We create a medical record of information about you and the care that you receive at the Medical Group. We need this record to provide you with high quality care. We are required by law to make sure that medical information about you is protected. We are also required by law to provide you a copy of this Notice and to comply with the current Notice.

The Medical Group’s medical staff, practitioners and non-practitioners who provide services in any Medical Group facility fall under the Joint Notice of Privacy Practices and may use and/or share your health information for treatment, to obtain payment for treatment, for administrative purposes, to evaluate the quality of care that you receive and for any and all other purposes described in this notice. Some medical providers in the Medical Group may be employed by the University of South Carolina School of Medicine and may be solely subject to the liabilities of the South Carolina Tort Claim Act. We reserve the right to change this Notice. The Notice will contain the effective date in the top right corner of the first page. A copy of our current Notice of Privacy Practices will be available for you upon request. You may also view the current Notice on the Medical Group’s website at <https://phuscmg.org>.

### **How we may use and disclose your protected health information without your written authorization**

**For treatment:** We use and disclose your protected health information to provide your medical care, both routine and emergent. Doctors, nurses, technicians, medical students and other health care staff may share your health information to plan, coordinate and manage your health care. For example, a doctor treating you for a broken arm would need to know about your diabetes since diabetes would probably slow your healing. We may also disclose medical information about you to family members or others involved in your treatment or in payment for your treatment.

**For payment:** We may use and disclose your protected health information to obtain payment for the treatment and services we provide for you. For example, we may give your health plan information about treatment you received from the Medical Group so that the health plan will pay us or reimburse you for the treatment. We may also tell your health plan about a treatment you are going to receive to have the treatment approved or make arrangements for payment. We may disclose to agencies and courts for collection of unpaid bills.

**For health care operations:** We may use and disclose protected health information about you for our administrative activities and operations that are needed to run the Medical Group. For example, we may use medical information to review our treatment to evaluate the performance of our staff in caring for you. We may ask that you sign in for your appointments and we may call your name in the waiting room. We may also disclose your information to doctors, nurses, health care students and other personnel for learning purposes. We may disclose your protected health information to comply with State and Federal law.

**For appointment reminders:** We may use and disclose protected health information to contact you by mail or phone or leave a message for reminding you of an appointment. The phone number that you give us may be used for automatic messages, unless you notify us to use another number.

**For treatment alternatives and services:** We may use and disclose protected health information to let you know about treatment options or health-related services that may be of interest to you.

**For “business associate” functions:** We may share your protected health information with our business associates that perform various functions for the Medical Group, such as billing and transcription service. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written agreement that contains terms to protect the privacy of your information.

**For abuse or neglect:** If we believe that you have been a victim of abuse, neglect or domestic violence, we may disclose your protected health information to an agency authorized to receive such information.

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

**For other required or permitted uses:** We may use and disclose your protected health information as required by law and to comply with the requirements of workers’ compensation, law enforcement, national security, military activities, organ donation, health

oversight agencies, coroners, funeral directors and public health authorities. We must provide, upon request, patients' protected health information to the Secretary of the Department of Health and Human Services. We may use and disclose your protected health information whenever necessary to respond to a serious threat to your health or safety or the health or safety of another person. For armed forces members and veterans, we may disclose your protected health information as required by military command authorities.

**For inmates:** We may use or disclose your protected health information whenever required.

**For fundraising:** We may use your information to contact you to raise funds for the benefit of the Medical Group by the Palmetto Health Foundation and USC Office of Development; however the patient has the right to opt-out of such communications.

For research: Under certain circumstances, we may use and disclose protected health information about you for research purposes. We may disclose your protected health information to people preparing to conduct a research project, for example, to help them look for patients with specific medical needs, so long as the protected health information does not leave the Medical Group. We may also disclose information to researchers when an Institutional Review Board has approved a research proposal and its protocols to ensure the privacy of your protected health information.

#### **Uses and disclosures of your protected health information based on your written authorization**

Some uses and disclosures of your protected health information may be made only with your prior written authorization. For example, disclosure for marketing purposes requires your authorization. You may revoke an authorization at any time, in writing, and we will no longer use or disclose medical information about you for the reasons covered by your written authorization. We cannot take back disclosures that have been made before the authorization is revoked.

#### **Your rights regarding your protected health information**

Although your medical record is the physical property of the Medical Group, you have the right to look at and obtain a copy of your medical record, except for psychotherapy notes and in certain circumstances. To inspect and copy your medical record, you must submit your request in writing to our receptionist who will forward your request to our office administration. In very limited circumstances we may deny your request. If you are not allowed to look at your record or receive a copy, in most cases you have the right to submit a written request for this decision to be reviewed. When you receive a copy of your medical record, the Medical Group may charge a fee for the associated cost.

You have the right to request in writing a restriction on certain uses and disclosures of your protected health information. We may not agree to a requested restriction. You have the right to be able to request in writing that we communicate with you by alternative means or at alternative locations and we will try to accommodate your requests. You have a right to request in writing an accounting of certain disclosures of your protected health information. Disclosures for treatment, payment and health care operations, as well as those with your signed authorization, are not included in an accounting. You have the right to have us restrict certain protected health information from disclosure to health plans where you pay out of pocket, in full, for the care and request such a restriction. Most uses and disclosures of psychotherapy notes uses and disclosures of protected health information for marketing purposes, and disclosures that constitute a sale of protected health information require authorization.

If you believe that the medical information we have about you is incorrect or incomplete, you have the right to request that your protected health information be amended. Your request must be in writing and must state the reason you are requesting the amendment. In certain cases, we may deny your request for the amendment. If we deny your request for the amendment, you have the right to file a statement of disagreement with us, and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive notifications whenever a breach of your unsecured PHI occurs. Other uses and disclosures not described in the Notice will be made only with authorization from the individual.

#### **Complaint process**

If you believe that your privacy rights have been violated by us, you may complain in writing, or by phone to the Department's Administrative Director, phone number 803-545-5690; or to the Medical Group's Privacy Officer, phone number 803-545-5692 ; or to the Secretary of the Department of Health and Human Services in Washington, DC. You will not be penalized in any way for filing a complaint. The Medical Group considers the privacy of your protected health information an important part of your health care.

**All Patients General Consent**

Patient's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ MRN: \_\_\_\_\_

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

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

\_\_\_\_\_  
Signature of Patient or Legally Qualified Representative

\_\_\_\_\_  
Date/Time

\_\_\_\_\_  
Printed Name of Patient or Legally Qualified Representative

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Palmetto Health-USC Medical Group Representative

\_\_\_\_\_  
Date/Time

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
DOB

\_\_\_\_\_  
MRN

**Do you want to designate a family member or other individual with whom the provider may discuss your medical condition?**

**If you are present and do not object**, Palmetto Health-USC Medical Group providers may discuss or share your health information with family members, friends, or others involved in your care or payment for your care. We may 1) ask your permission, 2) may tell you we plan to discuss the information and give you an opportunity to object, or 3) may decide, using our professional judgment, that you do not object. We may discuss only the information that the person involved needs to know about your care or payment for your care.

**I understand that I have the right to refuse to sign this authorization and that the Palmetto Health-USC Medical Group, will not condition my treatment on whether I provide authorization for the requested use or disclosure. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by law. I understand that I have the right to withdraw this authorization by sending a written notice to the Palmetto Health-USC Medical Group I understand that withdrawal is not effective for actions taken prior to the withdrawal.**

**If you are not around or cannot give permission**, we may share or discuss your health information with family, friends, or others involved in your care or payment for your care if we believe, in our professional judgment that it is in your best interest. When someone other than a friend or family member is asking about you, we must be reasonably sure that you asked the person to be involved in your care or payment for your care. We may only share the information that the family member, friend, or other person needs to know about your care or payment for your care. Palmetto Health-USC Medical Group will verify the identity of any person not known to us prior to disclosing health information.

If you would like to name specific family, friends, or others involved in your care or payment for your care with whom you would like us to share your health information, please list them in the space provided below. If you are not around or cannot give permission, we may rely on this information until you notify us otherwise; however, we may use our professional judgment to determine whether sharing your health information with these or other individuals is in your best interest.

<b>Name of family member, friend, or other person involved in patient's care or payment for care</b>	<b>Relationship to patient/involvement with patient's care or payment for care</b>

\_\_\_\_\_  
Patient's Signature or Legally Qualified Representative

\_\_\_\_\_  
Date/Time

\_\_\_\_\_  
Patient/Guardian Print Name

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Palmetto Health-USC Medical Group Representative

\_\_\_\_\_  
Date/Time