PATIENT REGISTRATION

Associated Medical Specialists, P.A. d/b/a Coastal Cancer Center ("CCC")

Office Use Only Date: ________________ Chart # ________________ Initial ________________

Name ________________________________ Sex (circle) M F

Date of Birth ________________ Age ________ Social Security # ________________

Martial Status (circle) Married Single Widowed Divorced Ethnicity (circle) Hispanic/Latino **NOT** Hispanic/Latino

Race (circle) American Indian or Alaska Native Asian Black or African American White

Preferred Language English ____________ Other ____________

Permanent/Primary Address ________________________________

City/State/Zip + 4 ________________________________

Temporary/Alternate Address ________________________________

City/State/Zip + 4 ________________________________

Preferred Mailing Address ☐ Permanent/Primary Address ☐ Temporary/Alternate Address

Phone: Home ( ) ____________ Cell ( ) ____________ Work ( ) ____________

Email Address ________________________________ Or Not Applicable ☐

Employment Status (Circle) 1-Full-time 2-Part-time 3-Not Employed 4-Self 5-Retired 6-Active Duty

Occupation ____________ Employer Name ____________ Phone ( ) ____________

Employer Address ________________________ City/State/Zip + 4 ________________

Disabled? ____________ Year ____________ Due To ____________

Guarantor Information

Guarantor Name ________________ Phone: Home ( ) ____________ Work ( ) ____________

Address (if different from Patient's) ________________ City/State/Zip + 4 ________________

Social Security Number ________________ Date of Birth ________________

Insurance Information

Primary Insurance ________________ Name of Subscriber *(if not patient) ________________

Secondary Insurance ________________ Name of Subscriber *(if not patient) ________________

Please complete only if subscriber on any policy is other than you, the patient

Subscriber Name ________________ Subscriber Date of Birth ____________ Subscriber Social Security # ____________

Relationship of Patient to Subscriber (please circle) Self Spouse Child Other: ____________

Subscriber Occupation ________________ Subscriber Employer ________________

Subscriber Employer Address ________________ City/State/Zip + 4 ________________

Subscriber Work Phone ( ) ____________ Full-time Part-time Not Employed Self Retired

Emergency Contacts/Who May We Notify?

Name ________________________________ Relationship ________________

Phone: Home ( ) ____________ Cell ( ) ____________ Work ( ) ____________

Address ________________________ City/State/Zip + 4 ________________

Name of Relative NOT Living with You ________________ Relationship ________________

Address ________________________ City/State/Zip + 4 ________________

Phone: Home ( ) ____________ Cell ( ) ____________ Work ( ) ____________

Name ______________________________ Chart number: ______________

CCC charges the Patient for all services it renders, regardless of insurance coverage. Please provide all insurance cards to the registrar upon arrival. A copy of insurance cards will be kept which makes it imperative for you, as the Patient, to inform us of a change in your coverage, work or other financial matters, as soon as it becomes known to you. Medicare, Medicaid and contracted insurers claims will be filed by this office. All other insurance claims are the responsibility of the Patient. Any assistance completing the forms may be offered as needed. Payment is expected for all services when rendered, unless previous arrangements in writing have been agreed upon.

GUARANTEE OF PAYMENT

In consideration for services, the patient and any Guarantor individually guarantee payment of all services provided to the Patient by CCC. This obligation of payment extends to all charges not paid by the Patient's insurance company or, if available, Medicare as stated below. By voluntarily signing this Guarantee, the Patient and Guarantor each agree to the payment of any outstanding charges and expenses arising from all services provided to the Patient. If the applicable insurance company does not pay within 30 days after any payment is due, payment is due from the Patient or Guarantor.

SIGNATURE ______________________________ DATE ______________________________

SPOUSE ______________________________ DATE ______________________________

MEDICARE PATIENTS

Medicare policies have a coinsurance and deductible. If Patient does not have supplemental coverage that covers coinsurance and deductible or if Patient has signed an Advance Beneficiary Notice, Patient agrees to be personally and fully responsible for payment. Patient requests that payment of authorized Medicare benefits be paid to CCC for services furnished. Patient authorizes CCC to release to the Centers for Medicare and Medicaid services or its agents, any information needed to determine these benefits or the benefits payable for related services.

SIGNATURE ______________________________ DATE ______________________________

SPOUSE ______________________________ DATE ______________________________

INSURANCE ASSIGNMENT AND AUTHORIZATION AND RELEASE AUTHORIZATION

In order to submit a claim for payment for services covered by a policy or program, such as Medicare, we must have your authorization to release medical information. I (Patient) authorize the release of any medical information relating to my charges with CCC. I authorize CCC to act in my behalf as authorized representative: (1) in the collection of benefits from any responsible third party through whatever means may be deemed necessary; and (2) in the endorsement of benefit checks made payable to myself and/or participant or insured. I request and authorize that benefit payment be made directly to CCC. Furthermore, I designate CCC as my authorized representative and authorize CCC to act on my behalf to (1) request and receive a copy of the summary plan description; (2) pursue a benefit claim and/or (3) appeal an adverse benefit determination. I understand that I am responsible for payment of my medical charges regardless of the status of any claim.

SIGNATURE (Patient) ______________________________ DATE ______________________________

SIGNATURE (Guarantor) ______________________________ DATE ______________________________

CONSENT TO TREAT

I request and give consent to my physician to provide and perform such medical/surgical care, tests, procedures, drugs and other services and supplies as are considered necessary or beneficial by my physician for my health and well being. I authorize the use and disclosure of my personal health information for the purposes of treatment and healthcare operations. I acknowledge that no representations, warranties or guarantees as to the results or cures have been made to me or relied upon by me.

SIGNATURE ______________________________ DATE ______________________________

COASTAL CANCER CENTER WITNESS ______________________________ DATE ______________________________

COASTAL CANCER CENTER

A division of Associated Medical Specialists, PA

Chart#: ______

8121 Rourk Street
Myrtle Beach, SC 29572
(843) 692-5000

817 Farrar Dr
Conway, SC 29526
(843) 234-1660

3008 Bayboro St
Loris, SC 29569
(843) 756-0932

4620 Highway 17
Murrells Inlet, SC 29576
(843) 357-7357

PATIENT MEDICAL HISTORY FORM

Last Name ______ First Name: ______ MI: ______ Date of Birth: ___/___/___ Age: ______

Notify in Emergency:
Name ______ Relationship ______
Street ______ Phone Number ______
City/State/Zip +4 ______

Do you have an advance directive (living will)? Yes ______ No ______ If yes, please provide a copy.

Local pharmacy: ______ Phone number: ______

Family physician: ______ Referring physician: ______

Chief Complaint And History Of Present Illness: What is the main reason for your visit today? (Describe your problem in detail)

______

______

______

Please answer the following questions about your present medical problem as it applies to you.

Cancer Pain Severity (If applies)

If pain is present, circle the number that best describes the level of pain with 4 being the most severe.

- 0 None
- 1 Mild pain not interfering with function.
- 2 Moderate pain; pain or analgesics interfering with function, but not interfering with activities of daily living.
- 3 Severe pain; pain or analgesics severely interfering activities of daily living.
- 4 Disabling pain.

Location

☐ Abdomen ☐ Back ☐ Breast ☐ Extremity
☐ Chest ☐ Head/Neck
Other ______

Duration

When did you first notice the problem?
Other ______

Modifying Factors

Does anything help or make the problem worse?
Moving around? Standing up? Lying on my side?
Other ______

Timing

How long does the problem last?

______

______

Associated Signs/Symptoms

Is anything else occurring at the same time? Please explain.

______

______

______

Context

Is the problem constant or variable?
Dull then Sharp? Very sharp then leaves? Always there?

______

Quality

Does the problem interfere with your normal functions?
Yes ☐ No ☐ If yes, please explain

______

PAST MEDICAL HISTORY: Please circle and list dates if you have had any of the following:

Condition	Y	N	Date:
Cancer	Y	N	______
Lymphoma	Y	N	______
Leukemia	Y	N	______
Blood Problem	Y	N	______
Connective Tissue Disease	Y	N	______
Arthritis	Y	N	______
Thyroid Problem	Y	N	______
High Cholesterol	Y	N	______
Other ______			

Condition	Y	N	Date:
Diabetes	Y	N	______
Kidney Disease	Y	N	______
Tuberculosis	Y	N	______
Appendix Removal	Y	N	______
Asthma	Y	N	______
Heart Disease	Y	N	______
High Blood Pressure	Y	N	______
Lung Disease	Y	N	______
Other ______			

Patient Name: ______________________________ Chart #______________________

Please list all prior hospitalization and surgery. Please do not list any pregnancies and/or births

	#1	#2	#3
Reason for admission (Medical reasons or diagnosis)	________	________	________
Month and year hospitalized	________	________	________
Type of Surgery (if one was done)	________	________	________

Have you EVER received radiation treatment for any illness? Yes No

If yes, for what illness? ______________________________

When was the treatment received? ______________________________

Have you EVER received chemotherapy treatment for any illness? Yes No

If yes, for what illness? ______________________________

When was the treatment received? ______________________________

MEDICATIONS:
List all medications, or drugs you currently use or have used at home within the last three months. Include those with a prescription from a doctor, those you bought over the counter in a store, any you received from a friend, any vitamins, home remedies, laxatives or any other product you take to improve your health. If you do not know all this information, please bring all the bottles or boxes with you to your next office visit. (Please attach an additional page if you need more space)

	Name & Strength of Medication	Amount taken	Approximate date started
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

ALLERGIES:
List anything (drugs, food, insects, pollens, etc.) you are **allergic** to:

	Item	Describe reaction you had
1.		
2.		
3.		
4.		

FOR WOMEN ONLY

Are you currently menstruating? Yes No

If yes, when did your last menstrual period begin? DATE ____/____/____

If you are post-menopausal, give approximate date. DATE ____/____/____

Please provide the following information:

Number of children born alive ____________

Number of miscarriages ____________

Are you on hormone replacement therapy? Yes No

Do you have abnormal vaginal bleeding? Yes No

Patient Name: ______________________________ Chart #______________

The following questions are about your **FAMILY**, you may not know all the information asked. Please answer to the best of your ability.

Please add additional information on the last page.

	NAME	LIVING	DEAD	PRESENT AGE OR AGE AT DEATH	HEALTH PROBLEMS	CAUSE OF DEATH IF DECEASED
Mother		☐	☐			
Father		☐	☐			
Brother		☐	☐			
Brother		☐	☐			
Brother		☐	☐			
Sister		☐	☐			
Sister		☐	☐			
Sister		☐	☐			

CHILDREN:	NAME	LIVING	DEAD	PRESENT AGE OR AGE AT DEATH	HEALTH PROBLEMS	CAUSE OF DEATH IF DECEASED
First		☐	☐			
Second		☐	☐			
Third		☐	☐			
Fourth		☐	☐			
Fifth		☐	☐			

Any history of cancer, leukemia or lymphoma in your family? If so, give details: ______________________________

____

____

____

SOCIAL HISTORY:

MARITAL STATUS: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

What is/was your job position? ______________________________

What was your last grade completed in school? ______________________________

What are your hobbies? ______________________________

Have you EVER smoked? ☐ Yes ☐ No

Do you now smoke? ☐ Yes ☐ No

If yes, average number of packs/day ______________

Number of years smoked ______________

Date stopped ______________ Do you desire counseling for smoking cessation? ☐ Yes ☐ No
If yes, please speak with your nursing staff.

Do you consume alcoholic drinks? ☐ Yes ☐ No

Amount:
- ☐ Never
- ☐ Rarely
- ☐ Moderately
- ☐ Socially
- ☐ Frequently
- ☐ Excessively

Do you now or have you ever had a problem with alcoholism or drug addiction? ______________

If you are of reproductive age (generally females age 18-40 and males age 18-50), do you desire to address fertility in regard to your diagnosis and treatment options? ☐ Yes ☐ No If yes, please speak with your nursing staff.

Patient Name: ______________________________ Chart #: ______________________

Review of Systems: Do you **CURRENTLY** have or are you **NOW** bothered with the following symptoms? Circle Yes or No

Constitutional Symptoms		
Fever	Y	N
Chills	Y	N
Fatigue/Excessively tired	Y	N
Weight loss	Y	N
Allergic/Immunologic		
Seasonal allergies	Y	N
Food allergies	Y	N
IV contrast allergies	Y	N
Drug allergies	Y	N
Eyes		
Sudden visual changes	Y	N
Excessive tearing	Y	N
Eye irritation	Y	N
Double vision/Blurred vision	Y	N
Ear/Nose/Throat/Mouth		
Hearing difficulty	Y	N
Dry mouth	Y	N
Mouth irritation	Y	N
Sore throat/Hoarseness	Y	N
Difficulty Swallowing	Y	N
Ear discomfort	Y	N
Sinus problem	Y	N
Ringing in the ears	Y	N
Endocrine		
Hot flashes	Y	N
Sweats	Y	N
Heat intolerance	Y	N
Cold intolerance	Y	N
Excessive Thirst	Y	N
Hematological/Lymphatic		
Easy bruising	Y	N
Easy bleeding	Y	N
Tender lymph nodes	Y	N
Swollen lymph nodes	Y	N
Breasts		
Abnormal breast mass	Y	N
Nipple Discharge	Y	N
Nipple pain	Y	N
Respiratory		
Wheezing	Y	N
Persistent cough	Y	N
Sputum production	Y	N
Shortness of breath	Y	N
Chest pain on breathing	Y	N
Coughing up blood	Y	N

Cardiovascular		
Heart pain (Angina)	Y	N
Irregular heart rhythm	Y	N
Congestive heart failure	Y	N
Varicose veins	Y	N
Extremity swelling	Y	N
Gastrointestinal		
Nausea	Y	N
Vomiting	Y	N
Diarrhea	Y	N
Constipation	Y	N
Abdominal pain	Y	N
Abdominal swelling	Y	N
Loss of appetite	Y	N
Indigestion/heartburn	Y	N
Blood in bowel movement	Y	N
Genitourinary		
Blood in urine	Y	N
Painful urination	Y	N
Frequent urination	Y	N
Hesitation on urination	Y	N
Incontinence	Y	N
Sexual dysfunction	Y	N
Genital Mass/tenderness	Y	N
Musculoskeletal		
Joint pain	Y	N
Swelling/edema	Y	N
Muscle aches	Y	N
Bone pain	Y	N
Decreased range of motion	Y	N
Integumentary		
Skin rash	Y	N
Lesions	Y	N
Skin breakdown	Y	N
Persistent itch	Y	N
Neurological		
Headaches	Y	N
Dizzy spells	Y	N
Numbness/tingling	Y	N
Weakness	Y	N
Unsteady balance when walking	Y	N
Tremor	Y	N
Psychological		
Are you generally satisfied with your life?	Y	N
Do you feel nervous or anxious?	Y	N
Do you have trouble sleeping?	Y	N
Do you have periods of extreme sadness or crying?	Y	N

______________________ ________

Patient Signature Date

______________________ ________

Physician Signature Date

ASSOCIATED MEDICAL SPECIALISTS, PA d/b/a COASTAL CANCER CENTER
EMAIL COMMUNICATION CONSENT

contactus@coastalcancercenter.com

Request for Email Use:

I request that Coastal Cancer Center; hereinafter referred to as CCC, communicate by email with me as needed for my/the patient's medical care. I have read, understand and agree to the terms for using email to communicate health information. I understand that:

1. By law, CCC cannot use or share my health information without my permission except as listed in CCC' s Notice of Privacy Practices.
2. CCC cannot promise security and confidentiality when emailing. CCC is not responsible if emails are incorrectly shared and someone other than CCC is at fault.
3. I can cancel this email consent at any time. I must cancel in writing and address it to the person or organization named above. I cannot cancel information already shared.
4. I do not have to sign this form. My refusal will not change this permission with respect to my ability to get treatment, payment for treatment or benefits. I understand that I will not be able to communicate by email with CCC if I do not sign this form.
5. Once information is sent to me by email, it may not be protected by law and someone may be able to share my information with others without my permission.
6. This request expires at the request of the patient or legal representative.

Risk of Using Email:

- Once you send an email, it may be intercepted, read and/or forwarded by someone without your permission.
- Email should **<u>not</u>** be used for emergencies or issues that must be handled quickly.
- Information that is particularly sensitive to you should not be sent by email.
- Employers can usually look at emails sent or received at work. Check your employer's policy before sending emails about your health from work.
- Email may not be delivered.

Conditions Regarding the Use of Email:

- Staff other than doctors or nurses may process and read emails sent to CCC.
- CCC saves all emails sent and received.
- It is up to you to call CCC if your email is not answered.
- If additional follow-up is needed, you must call and/or schedule an office visit.
- You must tell us why you are emailing in the subject line of the message. Examples include: medication refill, need an appointment or need a referral. **If you do not list a subject, your message will be deleted without being read.**
- The message must include the patient's name, telephone number and date of birth.
- CCC is not responsible for lost or misdirected emails.
- You are in control of emails sent to you by CCC. CCC is not responsible if you let someone else see your emails.
- CCC can change the terms of, or stop emailing, at any time. You will be told if this happens.
- If you do not receive a response to an e-mail, you are responsible for calling CCC to follow up.

____________________ ____________________ ____________

Patient Name (print) Patient/Representative Signature Date

____________________ Patient has: ☐ Accepted ☐ Declined

Patient Chart Number (print)

Legal authority to sign for patient: ☐ Guardian ☐ Attorney-In-Fact ☐ Healthcare Agent

☐ Other: ____________________

Patient is: ☐ Disabled ☐ Incapacitated

Patient Date of Birth: ____________ Email Address: ____________________

CCC Witness ____________________

Attention Patients & Guests

To best serve our practice,
Coastal Cancer Center
does not allow
guests and/or visitors
under fifteen (15) years of age
in the clinical areas
(e.g. laboratory, mixing center,
treatment room, shot area).

Thank you,
Your CCC Care Team

Associated Medical Specialists, PA
d/b/a Coastal Cancer Center
Authorization for Release of Information to Family and/or Friends

Patient Name:______________________________ Chart No.: ________________

Associated Medical Specialists, PA, d/b/a/ Coastal Cancer Center is authorized to release protected health information about the above named patient to the authorized people named below. This will enable Coastal Cancer Center to best coordinate your healthcare.

Print name	Relationship/Phone #	Please circle the information each person may receive:
		CLINICAL APPOINTMENT FINANCIAL
		CLINICAL APPOINTMENT FINANCIAL
		CLINICAL APPOINTMENT FINANCIAL

If you have additional people that you would like to receive information, please give them your passcode

If you have an answering machine or voice mail, may we leave a message regarding the following? **Y** **N**

Please circle each one signifying your consent CLINICAL APPOINTMENT FINANCIAL

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. 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.

This authorization shall be in effect until revoked by the patient or the patient's representative.

______________________________ ________________
Signature of Patient or Personal Representative Date

____
Description of Personal Representative's Authority (attach necessary documentation)

______________________________ ________________
Coastal Cancer Center Witness Date

Revised 09/23/2013

Associated Medical Specialists, PA
d/b/a Coastal Cancer Center

Notice of Privacy Practices

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

If you have any questions about this Notice, please contact our Privacy Officer at:
Coastal Cancer Center – Privacy Officer
8121 Rourk Street
Myrtle Beach, South Carolina 29572
(843) 692-5000

Effective date: April 1, 2003 **Revised: September 23, 2013**

We are committed to protect the privacy of your personal health information (PHI).

This Notice of Privacy Practices (Notice) describes how we may use within our practice or network and disclose (share outside of our practice or network) your PHI to carry out treatment, payment or healthcare operations. We may also share your information for other purposes that are permitted or required by law. This Notice also describes your rights to access and control your PHI.

We are required by law to maintain the privacy of your PHI. We will follow the terms outlined in this Notice. We may change our Notice, at any time. Any changes will apply to all PHI. Upon your request, we will provide you with any revised Notice by:

- Posting the new Notice in our office.
- If requested, making copies of the new Notice available in our office or by mail.
- Posting the revised Notice on our website: **www.coastalcancercenter.com**.

Uses and Disclosures of Protected Health Information

We may use or disclose (share) your PHI to provide healthcare treatment for you.

Your PHI may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing healthcare services to you.

EXAMPLE: Your PHI may be provided to a physician to whom you have been referred for evaluation to ensure that the physician has the necessary information to diagnose or treat you. We may also share your PHI from time-to-time to another physician or healthcare provider (e.g., a hospital) who, at the request of your physician, becomes involved in your care by providing assistance with your healthcare diagnosis or treatment to your physician.

We may also share your PHI with people outside of our practice that may provide medical care for you such as home health agencies.

We may use and disclose your PHI to obtain payment for services. We may provide your PHI to others in order to bill or collect payment for services. There may be services for which we share information with your health plan to determine if a service will be paid.

PHI may be shared with the following:

- Billing companies and collection agencies
- Insurance companies, health plans
- Government agencies in order to assist with qualification of benefits

EXAMPLE: You are seen at our practice for a procedure. We will need to provide a listing of services, such as labs, to your insurance company so that we can get paid for the procedure. We may at times contact your healthcare plan to receive approval PRIOR to performing certain procedures. This will require sharing of your PHI.

We may use or disclose as needed, your PHI in order to support the business activities of this practice which are called healthcare operations.

EXAMPLES:

- Training students, other healthcare providers, or ancillary staff such as billing personnel, to help them learn or improve their skills.
- Quality improvement processes which look at delivery of healthcare and for improvement in processes which will provide safer, more effective care for you.
- Use of information to assist in resolving problems or complaints within the practice.
- We may use a sign-in sheet at the registration desk where you will be asked to sign your name and we may call you by name in the waiting room.
- Our patients are treated in common settings such as the laboratory and chemotherapy area.

We may use and disclosure your PHI in other situations without your permission:

- If required by law: The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. For example, we may be required to report suspected abuse or neglect.
- Public health activities: The disclosure will be made for the purpose of controlling disease, injury or disability and only to public health authorities permitted by law to collect or receive information. We may also notify individuals who may have been exposed to a disease or may be at risk of contracting or spreading a disease or condition.
- Health oversight agencies: 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 healthcare system, government benefit programs, other government regulatory programs and civil rights laws.
- Legal proceedings: To assist in any legal proceeding or in response to a court order, in certain conditions in response to a subpoena, or other lawful process.

- Police or other law enforcement purposes: The release of PHI will meet all applicable legal requirements for release.
- Coroners, funeral directors: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law.
- Medical research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.
- Special government purposes: Information may be shared for national security purposes, or if you are a member of the military, to the military under limited circumstances.
- Health and Safety of Others: Information may be shared which is necessary for your health or the health and safety of other individuals.
- Workers' Compensation: Your protected health information may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally-established programs.

Other uses and disclosures of your health information:

Business Associates: Some services are provided through the use of contracted entities called "business associates." We will always release only the minimum amount of PHI necessary so that the business associate can perform the identified services. We require the business associate(s) to appropriately safeguard your information. Examples of business associates include our electronic medical record vendor and transcription services.

Health Information Exchange: We may make your health information available electronically to other healthcare providers outside of our facility who are involved in your care.

Fundraising activities: We may contact you in an effort to raise money. You may opt out of receiving such communications.

Treatment alternatives: We may provide you notice of treatment options, or other health related services, that may improve your overall health.

Appointment reminders: We may contact you as a reminder about upcoming appointments or treatment.

We may use or disclose your PHI in the following situations UNLESS you object.

- We may share your information with friends or family members, or other persons directly identified by you at the level they are involved in your care or payment of services. If you are not present or able to agree/object, the healthcare provider using professional judgment will determine if it is in your best interest to share the information. For example, we may discuss post treatment instructions with the person who drove you to the facility unless you tell us specifically not to share the information.

- We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death.
- We may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts.

The following uses and disclosures of PHI require your written authorization:

- Marketing.
- Disclosures of any purposes which require the sale of your information.
- Release of psychotherapy notes: Psychotherapy notes are notes by a mental health professional for the purpose of documenting a conversation during a private session. This session could be with an individual or with a group. These notes are kept separate from the rest of the medical record and do not include: medications and how they affect you, start and stop time of counseling sessions, types of treatments provided, results of tests, diagnosis, treatment plan, symptoms, prognosis.

All other uses and disclosures not recorded in this Notice will require a written authorization from you or your personal representative.

Written authorization simply explains how you want your information used and disclosed. Your written authorization may be revoked at any time but must be made in writing. Except to the extent that your doctor or this practice has used or released information based on the direction provided in the authorization, no further use or disclosure will occur.

Your Privacy Rights

You have certain rights related to your protected health information. All requests to exercise your rights must be made in writing. If you would like to make a written request, please ask for the HIPAA Privacy Officer or the Location Supervisor.

You have the right to see and obtain a copy of your protected health information.

This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. If requested, we will provide you a copy of your records in an electronic format. There are some exceptions to records which may be copied and the request may be denied. We may charge you a reasonable cost based fee for a copy of the records.

You have the right to request a restriction of your protected health information.

You may request for this practice not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. We are not required to agree with these requests. If we agree to a restriction request we will honor the restriction request unless the information is needed to provide emergency treatment.

There is one exception: we must accept a restriction request to restrict disclosure of information to a health plan if you pay out of pocket in full for a service or product unless it is otherwise required by law.

You have the right to request for us to communicate in different ways or in different locations.

We will agree to reasonable requests. We may also request an alternative address or other method of contact such as mailing information to a post office box. We will not ask for an explanation from you about the request.

You have the right to request an amendment of your health information.

You may request an amendment of your health information if you feel that the information is not correct along with an explanation of the reason for the request. In certain cases, we may deny your request for an amendment at which time you will have an opportunity to disagree.

You have the right to a list of people or organizations who have received your health information from us.

This right applies to disclosures for purposes other than treatment, payment or healthcare operations. You have the right to obtain a listing of these disclosures. If you request more than one list within a 12 month period you may be charged a reasonable fee.

Additional Privacy Rights

- You have the right to obtain a paper copy of this notice from us, upon request. We will provide you a copy of this Notice the first day we treat you at our facility. In an emergency situation we will give you this Notice as soon as possible.
- You have a right to receive notification of any breach of your protected health information.

Complaints

If you think we have violated your rights or you have a complaint about our privacy practices you can contact:

Coastal Cancer Center – Privacy Officer
8121 Rourk Street
Myrtle Beach, South Carolina 29572
(843) 692-5000

You may also complain to the United States Secretary of Health and Human Services if you believe your privacy rights have been violated by us.

If you file a complaint we will not retaliate against you for filing a complaint.

This notice was published and became effective April 1, 2003, Revised September 23, 2013

Associated Medical Specialists, PA
d/b/a Coastal Cancer Center

Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name: ______________________________ Chart No. _________________

I have received a copy of the Notice of Privacy Practices from the above named practice.

____ ____________________
Patient or Personal Representative Signature Date

____ ____________________
Coastal Cancer Center Witness Date

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

_____ An emergency existed & a signature was not possible at the time.

_____ The individual refused to sign.

_____ A copy was mailed with a request for a signature by return mail.

_____ Unable to communicate with the patient for the following reason: _______________

_____ Other: ____

Coastal Cancer Center printed name: ______________________________

Signature: ______________________________

Date: ______________________

Revised: 06/17/14