PRO HEALTH CENTER

Restoring Health. Hope. Life.

Justin Snider, DC, DABCI, ABAAHP Tanner Koon, APRN, FNP-C Jerett Tozzi, MD

Welcome to ProHealth Center!

On behalf of our practitioners and staff, we are honored that you have chosen us for your healthcare needs. Our mission is to provide you with outstanding, individualized care. To help us do this, we need certain information from you. ***Please complete the following forms (included in this patient welcome packet) and bring them with you to your first appointment***:

1. Patient Demographic Sheet
2. Patient Health Summary
3. Patient Questionnaire
4. Informed Consent to Treat
5. Financial Responsibilities & Policy
6. Appointment No-Show Policy
7. Well Care Appointment Policy
8. 30 Day Return Policy
9. Receipt of Notice of Privacy Practices
10. Notice of Privacy Practices

In addition to the completed forms, **please bring your driver's license/photo identification, insurance cards, and all current medications, supplements, and vitamins you are taking** (bring original containers if possible). Please arrive at least 15 minutes prior to your scheduled appointment time to give our front desk staff time to meet you and process your paperwork before your scheduled appointment time.

We are open from 8:00 AM to 5:00 PM Monday, Tuesday, and Thursday. Should you need to reach us after office hours for a nonemergency, you can email us at info@myprohealthcenter.com or message us on our Facebook page. Please allow up to 48 hours for a response. We do not have on call practitioners or answering service. If you have an emergency outside of our normal business hours, we recommend that you go to your closest Urgent Care facility or Emergency Room.

For Primary Care and some Urgent Care services, we accept Aetna, BlueCross BlueShield, and United Healthcare. We are legally bound by our contracts with those insurance companies to collect any copays, coinsurance, or deductibles at the time of service. Failure on our part to do so can result in cancellation or our provider contract. Patients who do not have insurance or are receiving any other service (other than primary care visit or urgent care visit) will be expected to pay the full fee at the time of service.

If you have any questions, please do not hesitate to call us at 864-681-0555. We are here to help. Again, welcome to ProHealth Center. We are happy to have you as a new member of our family and can't wait to meet you!

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PATIENT INFORMATION
(PLEASE PRINT)

☐ Mr. ☐ Ms. ☐ Dr. ☐ Mrs. ☐ Miss	Patient's Last Name:	First:	MI:
Marital status: ☐ Single ☐Married ☐ Divorced ☐ Separated ☐ Widowed	Preferred Name:	Birth/Maiden Name:	
Birth Date:	Gender:	SSN:	Email Address:
Preferred Language:	Race:	Ethnicity:	Driver's License Number: / State: / Exp. Date:
Home phone:	Work phone:	Cell phone:	
Address:	City:	State:	ZIP Code:
Occupation:	Employer & Address:	Employer phone:	
Referred by:	☐ Dr.	☐ Patient	☐ Other

INSURANCE INFORMATION
(PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

Person responsible for bill: (if self, please skip to Primary Insurance)			Is this person a patient at our practice? ☐ Yes ☐ No	
Date of Birth:	Address:		Home Phone:	
Occupation:	Employer & Address:		Employer phone:	

****Policy Holder's Name, SSN, Date of Birth and Relationship to Patient are <u>REQUIRED</u> to file all insurance claims.****

Primary Health Insurance Company:

*Policy Holder's Name:(as it appears on insurance card)		*SSN:		*Birth date:
Group Number:		Policy Number:		Co-Payment: $
*Patient's relationship to Policy Holder:	☐ Self	☐ Spouse	☐ Child	☐ Other

Secondary Health Insurance Company:

*Policy Holder's Name:(as it appears on insurance card)		*SSN:		*Birth date:
Group Number:		Policy Number:		Co-Payment: $
*Patient's relationship to Policy Holder:	☐ Self	☐ Spouse	☐ Child	☐ Other

IN CASE OF EMERGENCY (LOCAL FRIEND/ RELATIVE)

Name:	Relationship:	Phone #:	Alt. Phone #:
Name: (not living at same address)	Relationship:	Phone #:	Alt. Phone #:

The above information is true to the best of my knowledge. I authorize ProHealth Center or insurance company to release any information required to process my eligible claims. I authorize my insurance benefits be paid directly to the provider at ProHealth Center. I understand that I am financially responsible for any balance. I understand payment is due at the time of service, and that ProHealth Center reserves the right to dismiss patients that fail to keep their accounts current after reasonable attempts to collect payments have been made. I further agree to pay all costs and late fees should my account be turned over to collections.

Patient/Guardian Signature: _____ Date: _____

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Patient Health Summary

Patient Legal Name:_____ **Preferred Name:** _____

Today's Date: _____ **DOB:** _____ **SS#:** _____

DRUG ALLERGIES: Please list ALL medications you are allergic to.

1. _____ 3. _____ 5. _____
2. _____ 4. _____ 6. _____

PREVIOUS MEDICAL ILLNESSES: Please check any illnesses you have had in the past.

- ☐ Anemia / Low Blood
- ☐ Anxiety
- ☐ Asthma
- ☐ Bleeding from Bowels
- ☐ Bleeding Problems, Type: _____
- ☐ Blood Clot in Leg
- ☐ Blood Clot in Lung
- ☐ Blood Transfusion
- ☐ Cancer, Type: _____
- ☐ Communicable Disease, Type: _____
- ☐ Congestive Heart Failure
- ☐ Depression
- ☐ Diabetes / High Blood Sugar
- ☐ Emphysema / Chronic Bronchitis
- ☐ Epilepsy / Seizures
- ☐ Gallstones
- ☐ Glaucoma
- ☐ Gout
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Hepatitis/Liver Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV
- ☐ Irregular Heart Beat
- ☐ Kidney Disease, Type: _____
- ☐ Kidney Stones
- ☐ Prostate Problems
- ☐ Rheumatic Fever
- ☐ Skin Disease, Type: _____
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Ulcers in Bowels / Stomach
- ☐ Varicose Veins or Spider Veins
- ☐ Other: _____
- ☐ Other: _____
- ☐ Other: _____
- ☐ Other: _____
- ☐ Other: _____
- ☐ Other: _____
- ☐ Other: _____

SURGICAL HISTORY: Please provide dates for any surgeries you have had.

SURGERY	DATE
Appendectomy	
Joint Scope Surgery	
Biopsy	
Open Heart Surgery	
Neck Artery Surgery	
Cataract Surgery ☐ R ☐ L	
Gallbladder	
Broken Bone Repair	
Joint Replacement	

SURGERY	DATE
Back Disc Surgery	
Abdominal Surgery	
Tonsils Removed	
Prostate Surgery	
Vasectomy	
Tubal Ligation	
Hysterectomy (Complete? ☐ Y ☐ N)	
Mastectomy ☐ R ☐ L	
Other: _____	

CONTINUE →

Patient Health Summary, continued

CURRENT MEDICATIONS: Please list ALL medications you are currently taking. Include dosage and how often you take each medication.

Current Pharmacy: **Pharmacy Address:**		**Phone #:**
MEDICATION (including over-the-counter)	**DOSAGE**	**HOW OFTEN DO YOU TAKE?**

IMMEDIATE FAMILY HISTORY: Check beside any disease that has affected your mom, dad, brothers, and/or sisters.

☐	Heart Attack
☐	High Blood Pressure
☐	High Cholesterol
☐	Asthma
☐	Tuberculosis
☐	Liver Disease
☐	Kidney Disease

☐	Osteoporosis
☐	Stroke
☐	Epilepsy / Seizures
☐	Bleeding Problems
☐	Sickle Cell Anemia
☐	Diabetes / High Blood Sugar
☐	Thyroid Problems

☐	Cancer, Type:
☐	Alcohol Abuse
☐	Anxiety or Depression
☐	Glaucoma
☐	Other:
☐	Other:
☐	Other:

SPECIALISTS YOU ARE CURRENTLY SEEING:

Specialty	Specialist's Name	Location/Address	Phone Number

CURRENT HEALTH HABITS:

How often do you exercise? ☐ Never ☐ Occasionally ☐ Several Times Per Week ☐ Every Day

Have you ever smoked? ☐ Yes ☐ No	Number of Years: _____	How much do you/did you smoke every day? ____ # Cigarettes ____ # Packs

Do you use any of the following tobacco (other than cigarettes)?

☐ Pipe ☐ Snuff ☐ Cigars ☐ Chewing Tobacco ☐ Dip ☐ Electronic Cigarettes ☐ Vapor

Patient Health Summary, continued

Patient Name : _____ **DOB:** _____

Females ONLY:

Are you pregnant or planning to be pregnant soon? ☐ Yes ☐ No

Currently breast feeding? ☐ Yes ☐ No

Number of: Pregnancies? _____ Miscarriages? _____ Deliveries? _____

Have you ever had postpartum depression? ☐ Yes ☐ No ☐ Not Sure

If yes, how long did it last? _____

Current form of birth control: _____

Date of most recent: Pap smear? _____ **Mammogram**? _____

Any abnormal results? ☐ Yes ☐ No **What were they?**_____

Date of most recent menstrual period: _____ **How long is your typical menstrual period?** _____

Check all that apply:

☐ Irregular cycle ☐ Heavy bleeding ☐ Heavy clotting ☐ Excessive cramping ☐ Hormonal Headaches/Migraines

☐ Cystic Ance with cycle ☐ Hot flashes ☐ Bloating/water retention ☐ Bleeding for longer than 5 days ☐ Chewing

☐ Other:

OTHER: Please list anything else about you that will enable our practitioners to best care for you.

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Patient Questionnaire

Please answer as many questions as you can. Circle your answers and add comments if desired.

DATE: _____PATIENT NAME: _____DOB: _____

1. Tobacco Smoking Status:	Never / Former / Some Days / Everyday
2. If you smoke, describe how much you smoke:	_____
3. Smokeless tobacco status:	Pipe / Snuff / Cigars / Chewing Tobacco, Dip / Electronic Cigarettes, Vapor
4. Tobacco-years of use:	_____
5. E-cigarette/vape status:	Never/Former/Current
6. Most recent tobacco use screening:	_____
7. Do you have Advanced Directives in place?	Yes / No
8. Do you have a Medical Power of Attorney?	Yes / No
9. What is your current alcohol intake?	None / Occasional / Moderate / Heavy
10. Describe your current caffeine intake:	None / Occasional / Moderate / Heavy
11. Have you had any recent changes in family or social situations?	Yes / No
12. Describe your general stress level:	Low / Medium / High
13. Do you live alone or with others?	Alone / With Others
14. Are you exposed to passive (secondhand) smoke?	Yes / No
15. How would you describe the condition of your mouth and teeth, including false teeth or dentures?	Excellent / Good / Fair / Poor
16. How often do you see or talk to people that you care about & feel close to?	_____days a week
17. In the past year, have been unable to get medicine or medical care when it was really needed?	Yes / No
18. Do you have any family members with known mental health conditions?	Yes / No
19. Do you have any family members with known alcohol abuse?	Yes / No
20. Do you have any family members with known drug abuse? (Prescription/Non-Prescription)	Yes / No
21. Do you have any known mental health conditions?	Yes / No
22. Support systems or programs currently being used?	Yes / No
23. Are you legally blind in one or both eyes?	Yes / No
24. Are you hard of hearing or deaf in one or both ears?	Yes / No
25. Are able to care for yourself?	Yes / No
26. Do you have difficulty concentrating, remembering, or making decisions?	Yes / No
27. Do you have a caregiver?	Yes / No
28. Describe your activity level:	None / Occasional / Moderate / Heavy

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Informed Consent to Treat

I hereby request and consent to the treatment of any providers at ProHealth Center for procedures, including but not limited to, primary care, urgent care, consultations, joint or trigger point injections, blood draws, IM injections, photobiomulation therapy, decompression therapy, various modes of physio-therapy, diagnostic x-rays, chiropractic adjustments, specialty testing, IV therapies, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the providers of ProHealth Center and/or other licensed providers and support staff who now or in the future treat me while employed by, working or associated with or serving as back-up for the providers at ProHealth Center, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the providers at ProHealth Center and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments, procedures, and services.

I understand and I am informed that, as with all healthcare treatments, results are not guaranteed and there is no promise to cure. I further understand and I am informed that, as is with all healthcare treatments, in the practice of chiropractic and integrative medicine there are some risks to treatment, including, but not limited to, muscle spasms for short periods of time, aggravating and/or temporary increase in symptoms, lack in improvement of symptoms, fractures, disc injuries, strokes, dislocations, sprains, herxheimer reactions, fatigue, and flu like symptoms. I do not expect the provider to be able to anticipate and explain all risks and complications, and I wish to rely on the provider to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I further understand that chiropractic adjustments and supportive treatment is designed to reduce and/or correct subluxations allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, like all other health modalities, results are not guaranteed and there is no promise to cure.

Accordingly, I understand that all payment(s) for treatment(s) are final, and no refunds will be issued. However, prorated fees for unused, prepaid treatments will remain as a credit if I wish to cancel the treatment.

Any recommendations/consultations with respect to nutritional health, labs, diagnostic testing, diet, supplementation or detoxification is done exclusively for educational and information purposes and is not to diagnose or treat diseases and are for general guidelines only. The determination to take or withdraw from any medical intervention resides within the legislative authority of physicians and nurse practitioners. We support the distribution of current research and information relating to all topics and likewise encourage patients and clients to make informed health care decisions having researched and understood all balanced and accurate information to which those decisions pertain. In every case, please consult your medical physician regarding any changes you make to your medical regimen, as doing so without consultation or supervision by a qualified practitioner may be dangerous.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Name of Patient (Print): _____

Signature of Patient: _____ Date: _____

If patient is a minor:
Name of Parent/Guardian and Relationship to Patient: _____

Parent/Guardian Signature: _____ Date: _____

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Financial Responsibilities & Policy

We are honored to that you have chosen us to be your health care provider and appreciate you putting your trust in ProHealth Center. We are committed to the success of your health care and promise to give you our best. Prompt payment of your charges enable us keep our fees down, so please take a moment to familiarize yourself with our financial policies.

Insurance:

We participate with Aetna, BlueCross BlueShield, and United Healthcare insurance plans for Primary Care and some Urgent Care services ONLY and will bill participating insurance companies as a courtesy to you. You are expected to pay your deductible or copayments at the time of service. If we have not received payment from your insurance company within 45 days of the date of service, you may be expected to pay the balance in full. You are responsible to ensure all charges are paid whether by you or by your insurance company. **If you need assistance or have questions about insurance, please contact a member of our Financial Services Team between 9:00 AM and 3:00 PM, Monday, Tuesday, or Thursday at (864) 681-0555 ext.5.**

All other services are not eligible for our office to bill. If you would like to file your visits with your insurance company, we will be happy to provide you with a SuperBill that you can send in.

Co-Pays, Deductibles, Co-Insurances, and Payments:

Payment is required at the time services are rendered unless other arrangements have been made in advance. This includes applicable coinsurance and copayments for participating insurance companies. *Please remember patient responsibility amounts are determined by your individual insurance plans*, not ProHealth Center. *If you are not covered by insurance at the time of service or are receiving services that are not eligible to be filed, please be advised that you will be responsible for all charges incurred at the time of service.*

For your convenience we accept **cash, checks, MasterCard, Visa, American Express, Discover, and select HSA/FSA cards.** There is a $35.00 service charge for returned checks and your account will be put on a cash-only basis. Outstanding or overdue balances are due within 30 days unless prior arrangements have been made with our Financial Manager. If your balance is more than 90 days old, your account may be put in a hold status until further arrangements are made. **If you need assistance or have questions about payment, please contact a member of our Financial Services Team between 9:00 AM and 5:00 PM, Monday through Friday at (864) 681-0555 ext.5.**

Financial Policy, Continued Next Page

Financial Responsibilities & Policy, Continued

New Patient Appointment Deposit

When making a new patient appointment you will be asked to pay a $100 non-refundable deposit over the phone. This will secure your spot with us and serve as a credit to be applied towards the remaining balance due on the new patient appointment. Should you need to reschedule your appointment, the deposit will go towards the rescheduled visit as long as 24 business hours notice is given.
Thank you for your cooperation and understanding.

Card Service Fee

Please note that if paying with a credit/debit card or HSA/FSA card, there will be a service fee of 3.95% added to your total. This is a processing fee that goes to the credit card company and does not go ProHealth Center. If a card purchase needs to be refunded, the service fee will not be refunded and another service fee will possibly be added.

Non-Emergency Appointments:

We reserve the right to reschedule appointments if there is an overdue balance on your account or if a co-payment is not made at the time of service.

Dismissal Process:

There are several reasons that a patient may be dismissed from our practice. A few reasons are as follows:

- Failure to keep scheduled appointments
- Being verbally or physically abusive to staff
- Abuse of prescription drugs and/or failure to adhere to ProHealth Center's narcotic policy
- Failure to meet financial obligations

A letter will be sent to your last known address notifying you that you are being dismissed from our practice. If you have a medical emergency within thirty days of the date of the letter, one of our providers will be available for advice. After thirty days, you will no longer be seen at our practice by any provider. A copy of your medical records may be forwarded to your new doctor after a formal request is made.

Financial Policy Acknowledgement

Please do not sign below unless you have read the Financial Policy.

Patient Acknowledgement: I, _____, have read, understand, and agree to ProHealth Center's Financial Policy. I agree to pay for services rendered at the time of service. I also understand that ProHealth Center reserves the right to dismiss patients that fail to keep their accounts current after reasonable attempts to collect payments have been made. I also understand the terms of this Financial Policy may be amended by the practice without prior notification to the patient or guarantor due to changes in regulations or practice operations.

_____

Patient/Guardian Signature Date

You may also review this Financial Policy at prohealthcenter.com

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Appointment No-Show Policy

It is the policy of ProHealth Center to monitor and manage appointment no-shows. This is necessary to ensure that we are able to provide timely access to our providers for all patients. Unutilized appointments due to no-shows delays necessary care for other patients.

Scheduled appointments must be cancelled or rescheduled at least 24 business hours prior to the scheduled appointment time. Any patient who fails to arrive for a scheduled appointment without cancelling the appointment at least 24 business hours prior to the scheduled time is considered a "No-Show" and will be charged a $25 missed appointment fee.

After an established patient has three (3) no-show appointments, that patient and any person who is either a guarantor for, or guarantee of, the account in question may be discharged from our practice and asked to seek health care with another provider.

Patients seeking to establish care with ProHealth Center ("new patients") who fail to cancel or reschedule their initial appointment at least 24 business hours prior to the scheduled appointment are considered to be a "No Show", will be denied entry to the practice, and will not receive their nonrefundable deposit back.

A letter will be sent to your last known address notifying you that you are being dismissed from our practice. If you have a medical emergency within thirty days of the dates of the letter, one of our providers will be available for advice. After thirty days, you will no longer be seen at our practice by any provider. A copy of your medical records may be forwarded to your new doctor after a formal request is made.

Appointment No-Show Acknowledgement

Please do not sign this form unless you have read the Appointment No-Show Policy.

Patient Acknowledgement: I, _____, have read, understand, and agree to ProHealth Center's Appointment No-Show Policy. I understand that ProHealth Center reserves the right to dismiss patients that fail to show to their appointments as listed above.

_____

Patient/Guardian Signature Date

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Well Care Appointment Policy

Routine Preventive Physicals (also called Well Care Exams, Wellness Exams, Preventive Physicals or Routine Exams) are considered "well care" and do not address ANY problems, complaints, concerns, test results, ongoing health issues, new prescriptions or prescriptions refills.

A Wellness/Physical Exam includes a comprehensive history (with no chief complaint or present illness) and physical, age-appropriate counseling, screening labs and tests, and orders for vaccines appropriate for age and risk factors. Any services beyond this are unique to each patient health insurance plan.

Due to the variance of what is covered under each insurance plan, you are responsible for knowing and informing your provider what is covered under your plan.

I have verified my benefits/coverage with my insurance company and will inform my provider what services are covered as part of my wellness/physical exam. I understand that if my insurance company denies the preventive physical, or any portion thereof, I will be responsible for full payment of the exam. I further understand that anything discussed or addressed outside of my wellness exam can and will be billed in addition to this service.

Patient (Printed) Name Date of Birth

Patient Signature Date

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30 Day Return Policy

Thank you for purchasing from ProHealth Center!

We may offer a refund and/or exchange for eligible products* within the first 30 days of your purchase. If 30 days have passed since your purchase, you will not be offered a refund and/or exchange of any kind.

To be eligible for refund and/or exchange, your item must be unopened/unused and in the same condition you received it and in the original packaging. We will be glad to exchange the product for you if it was damaged or defective prior to purchase.

To receive a refund and/or exchange, you will need to notify a ProHealth Center front desk staff member of the issue within 30 days of purchasing. Before any refund and/or exchange will be made, the product must be returned to ProHealth Center for inspection and determination of approval or rejection.

*Eligible products may include essential oils, vitamins, supplements, pillows, coffee, diffusers, and any other retail products

Services already rendered are not eligible for return and/or exchange.

Patient (Printed) Name Date of Birth

Patient Signature Date

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IV Therapy Consent Form

This document is intended to serve as confirmation of informed consent for IV Therapy as ordered by a healthcare provider at ProHealth Center.

IVs are a complimentary treatment, and no promises of a curative treatment have been made. Alternative options to IV therapy are oral supplementation and/or dietary lifestyle changes. I understand that I have the right to refuse any proposed treatment before it is performed.

Initial (_____) I have informed the provider of my past medical history and any known allergies or past adverse reactions. I have informed the provider of my current medications, supplements, and ongoing therapies/treatments.

Benefits of IV therapy includes:

- Intravenous medications, supplements, and fluids are not affected by intestinal absorption issues.
- Total amount of infusion enters the bloodstream and is available to the body.
- Higher doses of nutrients can be given IV than orally.

Risks of IV therapy includes:

- Occasionally: Discomfort, bruising, and pain at the injection site from the needle/catheter insertion into the vein.
- Rarely: Inflammation of the vein, phlebitis, metabolic disturbances, and injury.
- Extremely Rarely: Severe allergic reaction, anaphylaxis, infection, cardiac arrest, or death.

I am aware that other unforeseeable complications can occur. I do not expect the provider to anticipate and/or explain all risks and possible complications. I rely on the provider to exercise judgement during treatment regarding my IV therapy.

Initial (_____) Labs are required to be collected with initial IV, and throughout IV care plan at the provider's discretion. I understand that services are typically not covered by insurance and are my responsibility.

Initial (_____) I understand that I have the right to refuse any proposed treatment before it is performed. I understand that I have been informed of the procedure, any feasible alternative options, and the risks and benefits of the aforementioned procedure. I have received all the information and explanation I desire concerning the procedure. I authorize and consent to the performance of the procedure.

Initial (_____) I also understand that the provider may choose to discontinue my IV treatment plan at any time in the interest of safety. (i.e.: lab refusal, abnormal labs, unforeseen reactions, etc.)

Printed Name:_____ Date: _____

Patient Signature:_____ Provider: _____

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Receipt of Notice of Privacy Practices

I hereby acknowledge that I have been given a copy of ProHealth Center's Notice of Privacy Practices, and further understand that any questions may be directed to the Privacy Officer/Practice Administer at ProHealth Center.

Patient Printed Name Date of Birth

Patient Signature Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

ProHealth Center
Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PROVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY: We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your personal health information (PHI). We must follow the privacy practices that are described in the Notice while it is in effect. This Notice takes effect July 2, 2018 and will remain in effect until we replace it. We reserve the right to change our privacy practices & the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices & the new terms of our Notice effective for all health information that we maintain, including PHI we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request. You may request a copy of our Notice at any time. For more information about our privacy practices or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES & DISCLOSURES OF PHI: We use & disclose health information about you for the purposes of treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your PHI to a physician or other healthcare provider providing treatment to you or for referring you for additional care.

Payment: We may use or disclose your PHI to obtain payment for services we provided to you.

Healthcare Operations: We may use or disclose your PHI in connection with our healthcare operations. Healthcare operations include, but are not limited to, quality assessment & improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluation practitioner & provider performance, conducting training programs, accreditation, certification, licensing, medical review, legal services, or credentialing activities.

Your Authorization: In addition to our use of your PHI for treatment, payment, or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your PHI to you, as described in the Patient Rights section of this Notice. We may disclose your PHI to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose your PHI to notify or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your PHI for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your PHI to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your PHI to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal official's health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your PHI to provide you with appointment reminders (such as voicemail messages, text messages, postcards, letters, etc.).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your PHI, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practically do so. All requests to obtain your PHI must be in writing. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the bottom of this Notice. If you request copies, we will charge you $1.00 per page, $20.00 per hour (with a minimum of $20.00) for staff time to locate and copy your PHI, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your PHI in that format. Contact us at the number listed below for a fee structure.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than treatment, payment, healthcare operations and certain other activities. If you request this accounting more than once in a 12-month period, we will charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your PHI. We are not required to agree to these additional restrictions.

Alternative Communication: You have the right to request that we communicate with you about your PHI by alternative means or to alternative locations. **{You must make your request in writing.}** Your request must specify the alternative means or location and provide a satisfactory explanation of how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your PHI. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Website or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS & COMPLAINTS: If you want more information about our privacy practices or have questions or concerns, please contact us. Contact Officer: Katy Snider. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your PHI or in response to a request you made to amend or restrict the use or disclosure of your PHI or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request. We support your right to the privacy of your PHI. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer and Information: Katy Snider 864-681-0555 katy@myprohealthcenter.com 500 Plaza Circle, Suite J, Clinton, SC 29325