HIPAA Notice of Privacy Practices

Greenville Women's Clinic
1142 Grove RD.
Greenville S.C. 29605
(864) 232-1584
1-800-776-0082

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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information
Your protected health information 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 health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.
Your Rights
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for 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 an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on/or before April 14, 2003.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name: __________________________

Signature_________________________ Date_________________________
RELEASE

I, the undersigned, understand that the state of South Carolina has required that all persons receiving a first trimester abortion be tested for gonorrhea and chlamydia and I understand I have the right to refuse these tests. Gonorrhea and chlamydia are sexually transmitted diseases and if the results of the tests are positive, that information will be reported to the State Health Department as required by law. I understand that I will have to obtain treatment from the Health Department or my family physician. I release and discharge the Greenville Women’s Clinic from any and all claims arising out of the requirements of having this test and any treatment needed should the tests be positive. I accept full responsibility for obtaining treatment for these conditions if I am found to be positive.

If you agree to take this test there will be an additional $40.00 charge.

I have read the above and I agree to take both tests.

_________________________________________  X________________________
Witness                        Patient Signature

Date

I have read the above and I refuse both tests.

_________________________________________  X________________________
Witness                        Patient Signature

Date
MEDICAL HISTORY

Date of Last Normal Menstrual Period

Height __________ Weight __________

Number of Previous Pregnancies __________ Number Delivered __________ Number Abortions __________ Number Miscarriages __________

Date of your delivery __________ Date of your last abortion __________

Date of last Pap Smear __________ and what was the result?

Month __________ Year __________

Syphilis Serology & Pap Smear Available At Extra Charge YES ______ OR ______ NO ______

CHECK YES OR NO IF YOU EVER HAD THE FOLLOWING CONDITIONS: YES ______ NO ______

--- ALLERGY TO LATEX?
--- ALLERGY TO PENICILLIN?
--- OTHER MEDICINE ALLERGIES?
--- TAKING ANY MEDICATION?
--- REACTION TO NOVOCAINE?
--- SURGERY?
--- RECENT HOSPITALIZATION?
--- TUBAL LIGATION/"TUBES TIED"
--- CURRENTLY BREAST FEEDING?
--- DIABETES?
--- GENERAL ANESTHESIA BEFORE?
--- SICKLE CELL ANEMIA?

EXPLAIN ANY QUESTIONS ANSWERED YES:

I have supplied all the answers in the foregoing and have carefully reviewed the form completed with my answers inserted, and the same are true and correct. This ______ day of __________________ 20___

Witness _______ Patient _______

PHYSICIAN NOTES

PREOPERATIVE:
GENERAL PHYSICAL CONDITION: GOOD

ABDOMEN: SOFT, NON TENDER
PELVIC: ANTERIOR OR POSTERIOR
ESTIMATED DURATION OF PREGNANCY BASED ON SIZE OF UTERUS: __________ WEEKS

HEART

LUNGS

RESPIRATIONS

POST OPERATIVE:
OPERATION: SUCTION CURETTAGE
ANESTHESIA: GENERAL, IV OR LOCAL, LIDOCAINE 1%
ESTIMATED BLOOD LOSS: __________ ML

SPECIMEN OBTAINED? APPROPRIATE OR SMALL

POST-OPERATIVE CONDITION: GOOD

COMMENTS:

DISCHARGE NOTE:

DATE:

SIGNATURE OF SURGEON
PRE-OPERATIVE CHART

UCG ___________ Hgb ___________
TEST PACK ___________ Temp ___________
GP2 URINE STICK
GLUC ___________ Rh Type ___________
PROT ___________ Anti D ___________

DATE ___________ TIME CHARTED ___________ CHARTED BY ___________

Pre-Medication ___________ Time ___________

Time ___________

Signed:

Counseling:

Abortion and Birth Control Methods Discussed
Patient Confident with Decision

Environmental form sent on: by: Signed:

Operative

Signed:

GENERAL ANESTHESIA:

NPO p MN
ASA 1 11 111
COMMENTS:

PRE INDUCTION BP P R
TIME:
IV BUTTERFLY INTRACATH
HAND WRIST ANTICUBITUS
PRECORDIAL STETHOSCOPE

Atropine ___________ mg IV
Inaspine ___________ mg IV
Propofol 1% ___________ mg IV
N2O ___________ L SCCF
02 ___________ L SCCF
Pitocin ___________ Units IV
Methergine .2 ___________ mg IM
Post-op BP ___________ P ___________ R ___________

Signed C.R.N.A.

Recovery Room: Time Entered ___________ Time Left ___________
Ergonovine Maleate 0.2 mg p.o. Yes No
Contraception ___________ SMOKER / NON SMOKER
Doryx 100 mg -1 capsule for 2 days to go home
Ergonovine Maleate 0.2 mg -1 tablet 3 times a day for 2 days to go home Yes No
Tylenol 2-5 grain tablets p.o. given Yes No

B/P ___________ B/P ___________
P ___________ P ___________
R ___________ R ___________

Post Operative Instructions Explained Yes No Signed

Condition at Discharge: Good Other: Physicians Signature
PATIENTS' BILL OF RIGHTS

The statements below are not laws but are beliefs and values of the Greenville County Medical Society doctors who want to maintain strong, trusting-doctor relationships.

THE PATIENT HAS THE RIGHT TO:

- A doctor who stands up for the benefit of the patient and an insurance company which respects this role.
- Advice from his or her personal doctor, even when that advice may not agree with the opinion of the insurance company or the services listed in the insurance plan.
- Be told his or her doctor's referral specialist-of-choice (surgery, heart, cancer are examples), even when the specialist is not a provider for the insurance plan.

PATIENTS HAVE THE RIGHT TO KNOW - BEFORE SIGNING THE INSURANCE PLAN AND SIXTY DAYS IN ADVANCE OF ANY CHANGES:

- Limits to the medical services covered
- Limits in their choices of doctors or hospitals
- Any money incentives offered to the doctor by the insurance plan which might affect the care given.

THE PATIENT HAS THE RIGHT:

- To be able to choose independent doctors rather than network or “preferred” doctors for a higher patient payment that is still affordable.
- To coverage for the same tests, procedures and treatments as any other patient with similar problems, in the same insurance plan, as ordered by his or her doctor.
- To confidential medical records. If releasing records to an insurance company, the patient should be able to limit what is seen by the company for any reason allowed by law.
- To an appeals process provided by the insurance company: when medical service is denied or limited. The insurance company should be legally responsible for the decisions it makes about insured patients.
- To be protected from loss of insurance if he or she makes a reasonable complaint against the insurance company. The patient's doctor should also be protected from loss when making or supporting a complaint for the patient.
- To know which government agency can help when the insurance company and the patient differ about coverage of a medical service. This information should be in the plan's benefits booklet.

SIGN: ____________________________

DATE: ____________________________

GREENVILLE COUNTY MEDICAL SOCIETY
1395 SOUTH CHURCH STREET * GREENVILLE, S.C. 29615* (864) 370-9083