



WELCOME TO USC PULMONARY CLINIC

Appointment day: Please arrive **30 minutes** before your first appointment. Please bring your insurance card and driver's license or picture I.D. Please bring a complete, up-to-date list of all medications you take or bring the bottles/packages with you. Also, please bring your current CT Scans or MRIs on a *disk* if they were done outside the Palmetto Health system. **You will be rescheduled if you are not on time to your appointment or a pulmonary function test.** If special circumstances arise, please call the office immediately at 803-799-5022.

Co-Payments and Billing: Co-pays are expected at the beginning of your appointment. **If you cannot provide your co-payment, you will be rescheduled.** Please call the number on the back of your insurance card to determine what your specialty co-pay is. We are not responsible for obtaining any prior authorizations for your appointment. All balances must be paid in full OR special payment arrangements must be made PRIOR to your next appointment.

Specialty Clinics: We are proud to offer general pulmonary, interventional pulmonary, nodule, sleep, asthma, interstitial lung disease, sarcoidosis, cystic fibrosis, respiratory insufficiency and pulmonary hypertension clinics. There may be times when your physician will transfer you to one of these clinics if your case requires more intensive evaluation. During your visit, you may be seen by a pulmonary fellow, who is a physician specializing in pulmonary medicine, along with the attending pulmonologist.

Walk-In Clinic: We are very excited to offer this service!! This clinic is for established patients only. NO test results will be discussed at this visit. If you missed your last appointment **you are not eligible** for walk-in until you have been seen at a regularly scheduled visit. If you are experiencing non-urgent pulmonary issues, please come to our office between 7:30am and 8:30am and you *may* be seen by the physician on duty if your symptoms meet our requirements for walk-in clinic. We strongly encourage you to arrive by 8:00am if you want to be seen in the clinic that day.

Prescription Refills: Messages for refills may be left on our prescription line during business hours. Please leave: your name, date of birth, your doctor's name, your medication and dosage, your pharmacy and phone number. Please speak slowly and spell your last name. You will not receive a return phone call from us, so please check with your pharmacy. Please allow us a minimum of **24 hours** to process your request. Multiple phone calls will delay your response. **As a general policy, we do not prescribe narcotic medications.**

Forms: **We do not fill out any evaluations for permanent disability or workers' compensation.** We will be glad to provide records to your evaluator. Your doctor may consider filling out other types of forms. You may drop them off or bring them to your visit, but you should allow a minimum of one week to fill these out.

No Show Policy: **You must cancel your appointment at least 24 hours in advance.** Calls to cancel the same day as the appointment will be considered "no show" visits and you may be charged a fee. We reserve the right to release you from our care if you have 3 "no shows".

Samples: Medication samples *may* be given at your physician's discretion. We have a very limited supply. For this reason, they will only be given at scheduled appointments and they are given as a priority to new starts on a medication.

Hours: Our office is open from 7:30AM to 4:30 PM Monday through Friday. All phone calls will be returned within 24 hours. If you experience a life-threatening medical emergency, please call 911.

_____ (initials) I have read and understand USC Pulmonary and Sleep Clinic's general policies.

1 Richland Medical Park Dr. Suite 300
Columbia, SC 29203
Phone: 803-799-5022.

For more information please visit our website at: www.uscpulmonary.com

**UNIVERSITY SPECIALTY CLINICS
Patient Registration**

Date: _____

PATIENT INFORMATION

Patient Name: _____ Sex: M F Race: _____ DOB: ____/____/____

Address: _____ City: _____ State: _____ Zip: _____ County: _____

Home phone#: _____ Work phone #: _____ Cell Phone #: _____

Social Security #: _____ Marital Status: _____ Email Address: _____

Primary Care Physician: _____

Employer Name/Address: _____

EMERGENCY CONTACT (Not your home phone please)*

Name: _____ Phone#: _____ Relationship: _____

*PERSON RESPONSIBLE FOR PAYING (IF DIFFERENT FROM PATIENT)
Or Subscriber for primary insurance*

Responsible Person's Name: _____ Relationship to patient: _____

Address: _____ City: _____ State: _____ Zip: _____ County: _____

Home phone#: _____ Work phone #: _____ DOB: ____/____/____

Social Security #: _____

Employer Name and Address: _____

INSURANCE INFORMATION

1. INSURANCE COMPANY: _____ Phone#: _____ Employer _____

Mailing Address: _____

Policy# _____ Group# _____ Subscriber's Name _____

Subscriber's Birth Date _____ Subscriber's SS # _____ Relationship to patient _____

2. INSURANCE COMPANY: _____ Phone#: _____ Employer _____

Mailing Address: _____

Policy# _____ Group# _____ Subscriber's Name: _____

Subscriber's Birth Date _____ Subscriber's SS # _____ Relationship to patient _____

Patient Signature _____ Date _____



USC PULMONARY PATIENT QUESTIONNAIRE

(Please complete prior to your office visit)

Name: _____ Age: _____ Date: _____

Reason for Visit: _____ Referring MD: _____

SYMPTOMS: Please check all current symptoms

<input type="checkbox"/> Cough <input type="checkbox"/> Sputum production <input type="checkbox"/> Coughing up blood <input type="checkbox"/> Wheezing <input type="checkbox"/> Sinus Drainage <input type="checkbox"/> Sore Throat	<input type="checkbox"/> Fever <input type="checkbox"/> Chills <input type="checkbox"/> Night Sweats <input type="checkbox"/> Leg swelling <input type="checkbox"/> Weight Loss <input type="checkbox"/> Chest pain	<input type="checkbox"/> Shortness of breath at rest <input type="checkbox"/> Shortness of breath with exertion <input type="checkbox"/> Sleep on several pillows or in a chair <input type="checkbox"/> Stop breathing while sleeping <input type="checkbox"/> Waking up short of breath
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Med Allergies No Yes Please list drugs and reactions: _____

Preferred pharmacy _____

MEDICAL HISTORY: please check all conditions that you have or have had

Condition	Condition	Medication Name	Dose	Times per day
<input type="checkbox"/> Asthma	<input type="checkbox"/> Anemia	_____	_____	_____
<input type="checkbox"/> Emphysema	<input type="checkbox"/> Sickle Cell Disease	_____	_____	_____
<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> High Blood Pressure	_____	_____	_____
<input type="checkbox"/> Allergies	<input type="checkbox"/> Hypo/Hyperthyroidism	_____	_____	_____
<input type="checkbox"/> Sarcoidosis	<input type="checkbox"/> Migraine Headaches	_____	_____	_____
<input type="checkbox"/> Sleep Apnea	<input type="checkbox"/> Seizures	_____	_____	_____
<input type="checkbox"/> Heart Failure	<input type="checkbox"/> HIV	_____	_____	_____
<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Stroke	_____	_____	_____
<input type="checkbox"/> Hypertension	<input type="checkbox"/> Mental illness_____	_____	_____	_____
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Glaucoma	_____	_____	_____
<input type="checkbox"/> Stomach Ulcer	<input type="checkbox"/> Cancer or Leukemia	_____	_____	_____
<input type="checkbox"/> Liver Disease	Type:_____	_____	_____	_____
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Other:_____	_____	_____	_____
<input type="checkbox"/> Gout	_____	_____	_____	_____
<input type="checkbox"/> Kidney Stones	_____	_____	_____	_____
<input type="checkbox"/> Kidney Failure	_____	_____	_____	_____

SURGICAL HISTORY:

Surgery:_____ Year:_____	Surgery:_____ Year:_____
Surgery:_____ Year:_____	Surgery:_____ Year:_____

SOCIAL / PERSONAL HISTORY: Please complete the following information about yourself

<p>Occupation: Type of work you have done in the past: _____ <input type="checkbox"/> Unemployed <input type="checkbox"/> Retired <input type="checkbox"/> Disabled</p> <p>Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Divorced</p> <p>Tobacco Use: <input type="checkbox"/> Never <input type="checkbox"/> Current <input type="checkbox"/> Quit <input type="checkbox"/> Age you quit:_____</p> <p>Type: <input type="checkbox"/> Cigars <input type="checkbox"/> Pipe <input type="checkbox"/> Dip <input type="checkbox"/> Cigarettes Age you started:_____ # packs/day_____</p> <p># of Years smoked:_____</p>	<p>Exposed to: <input type="checkbox"/> Second hand smoke <input type="checkbox"/> Asbestos <input type="checkbox"/> Chemical fumes <input type="checkbox"/> Radiation <input type="checkbox"/> Mining</p> <p>Alcohol Use: <input type="checkbox"/> Never <input type="checkbox"/> Occasionally (__drinks per __) Daily <input type="checkbox"/> Quit Type: <input type="checkbox"/> Beer <input type="checkbox"/> Wine <input type="checkbox"/> Liquor</p> <p>Drug Use: <input type="checkbox"/> Never <input type="checkbox"/> Occasionally <input type="checkbox"/> Daily Types:_____</p> <p>Exercise: <input type="checkbox"/> Regularly <input type="checkbox"/> Occasionally (____ per ____) <input type="checkbox"/> Rarely</p>
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FAMILY HISTORY: List any medical problems

Father: _____ Mother: _____	Brother/Sister: _____ Grandparents: _____
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REVIEW OF SYSTEMS: please check any item which describes recent or ongoing symptoms

General:	<input type="checkbox"/> None apply
<input type="checkbox"/> Significant weight loss <input type="checkbox"/> Loss of feeling of well-being <input type="checkbox"/> Fatigue or loss of energy <input type="checkbox"/> Difficulty sleeping Comment: _____	
Eyes:	<input type="checkbox"/> None apply
<input type="checkbox"/> Blurred vision <input type="checkbox"/> Double vision <input type="checkbox"/> Seeing spots <input type="checkbox"/> Eye pain <input type="checkbox"/> Need glasses <input type="checkbox"/> Cataract <input type="checkbox"/> Glaucoma Comment: _____	
Ear – Nose – Throat:	<input type="checkbox"/> None apply
<input type="checkbox"/> Hearing loss <input type="checkbox"/> Ringing in your ears <input type="checkbox"/> Dizziness <input type="checkbox"/> Sore throat <input type="checkbox"/> Breath odor <input type="checkbox"/> Hoarseness <input type="checkbox"/> Chronic nasal congestion <input type="checkbox"/> Sinus infections <input type="checkbox"/> Nose bleeds <input type="checkbox"/> Toothaches /Bleeding gums Comments: _____	
Respiratory:	<input type="checkbox"/> None apply
<input type="checkbox"/> Shortness of breath <input type="checkbox"/> Cough <input type="checkbox"/> Chest congestion <input type="checkbox"/> Wheezing <input type="checkbox"/> Coughing up blood <input type="checkbox"/> Choking <input type="checkbox"/> Noisy breathing <input type="checkbox"/> History of pneumonia <input type="checkbox"/> History of or exposure to tuberculosis (TB) Comment: _____	
Cardiovascular:	<input type="checkbox"/> None apply
<input type="checkbox"/> Chest pain <input type="checkbox"/> Heart fluttering or racing <input type="checkbox"/> Heart murmur <input type="checkbox"/> Decreased exercise tolerance <input type="checkbox"/> Awakening due to shortness of breath <input type="checkbox"/> Difficulty breathing when lying down <input type="checkbox"/> Leg swelling <input type="checkbox"/> Pain in buttocks or legs with exercise <input type="checkbox"/> Sensitivity of hands or feet to temperature changes Comments: _____	
Breast:	<input type="checkbox"/> None apply
<input type="checkbox"/> Breast lump <input type="checkbox"/> Breast pain <input type="checkbox"/> Breast cancer Comment: _____	
Gastrointestinal:	<input type="checkbox"/> None apply
<input type="checkbox"/> Stomach pain <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> History of taking diet pills <input type="checkbox"/> Frequent heartburn/ Indigestion <input type="checkbox"/> Belching or sour taste <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Bloating <input type="checkbox"/> History of hepatitis/ yellow jaundice <input type="checkbox"/> Rectal bleeding <input type="checkbox"/> Rectal pain or irritation <input type="checkbox"/> Hemorrhoids Comments: _____	
Genitourinary (Men only):	<input type="checkbox"/> None apply
<input type="checkbox"/> Frequent urination (<input type="checkbox"/> often at night) <input type="checkbox"/> Pain on urination <input type="checkbox"/> Prostate problems	
Genitourinary (Women only):	<input type="checkbox"/> None apply
<input type="checkbox"/> Frequent urination (<input type="checkbox"/> often at night) <input type="checkbox"/> Frequent urinary infections <input type="checkbox"/> Blood in urine Comment: _____	
Lymphatic / Hematologic:	<input type="checkbox"/> None apply
<input type="checkbox"/> Unusual lymph node swelling <input type="checkbox"/> Painful lymph nodes <input type="checkbox"/> History of cancer type: _____ <input type="checkbox"/> History of anemia <input type="checkbox"/> Blood clots <input type="checkbox"/> Bruise easily <input type="checkbox"/> Unusual bleeding Comment: _____	
Musculoskeletal:	<input type="checkbox"/> None apply
<input type="checkbox"/> Limb or joint pain <input type="checkbox"/> Limb or joint swelling / stiffness / redness <input type="checkbox"/> Muscle weakness <input type="checkbox"/> Loss of muscle bulk <input type="checkbox"/> Muscle spasms or twitching <input type="checkbox"/> Recurring back pain <input type="checkbox"/> Neck pain <input type="checkbox"/> Back injury <input type="checkbox"/> Neck injury Comment: _____	
Neurologic:	<input type="checkbox"/> None apply
<input type="checkbox"/> Seizures <input type="checkbox"/> Tremors <input type="checkbox"/> Unusual clumsiness <input type="checkbox"/> Limb weakness <input type="checkbox"/> Numbness / tingling <input type="checkbox"/> Stroke <input type="checkbox"/> Passing out <input type="checkbox"/> History of head injury <input type="checkbox"/> Chronic headaches Comment: _____	
Psychologic / Sleep:	<input type="checkbox"/> None Apply
<input type="checkbox"/> Lapse in memory <input type="checkbox"/> confusion <input type="checkbox"/> Difficulty concentrating <input type="checkbox"/> Depression <input type="checkbox"/> Mood swings <input type="checkbox"/> History of mental illness <input type="checkbox"/> History of physical or mental abuse <input type="checkbox"/> Snoring <input type="checkbox"/> Daytime sleepiness Comment: _____	
Endocrine:	<input type="checkbox"/> None apply
Unexpected changes in: Tolerance to heat <input type="checkbox"/> Tolerance to cold <input type="checkbox"/> Unusual thirst Comment: _____	
Allergy / Immunology:	<input type="checkbox"/> None apply
<input type="checkbox"/> Seasonal allergies <input type="checkbox"/> Frequent or unusual infections (ie. Bronchitis) <input type="checkbox"/> Sensitivity to specific items: _____	
Skin:	<input type="checkbox"/> None apply
<input type="checkbox"/> Itching <input type="checkbox"/> Rash <input type="checkbox"/> Unusual dryness <input type="checkbox"/> Changes in hair <input type="checkbox"/> Changes in pigmentation Comment: _____	
MD or NP Signature: _____	Date: _____



Authorization Regarding Payment and Release of Medical Information

Patient's Name: _____ Chart #: _____

I hereby authorize and request the payment of services from Medicare, Medicaid and/or other insurance plans or payors be made on my behalf to University Specialty Clinics – _____. I hereby assign to University Specialty Clinics – _____ all payments for treatment services. I hereby allow University Specialty Clinics to file an appeal for me with Medicare, Medicaid and/or other insurance plans or payors for any reason. I understand and agree that I am responsible for paying any amount not covered by Medicare, Medicaid and/or other insurance plans or payors.

(PLEASE READ THE ATTACHED FINANCIAL AND INSURANCE POLICY FOR OUR PRACTICE)

I hereby authorize the release of medical information to Medicare, Medicaid and/or insurance plans or other payers. I also authorize the release of medical information to other healthcare providers including, but not limited to, my primary care or family physician, consulting physicians or healthcare providers, hospitals, rehabilitation center, or other healthcare providers or facilities. I authorize my healthcare providers to review my prescription history from my pharmacist(s) for purposes of treatment. I permit a copy of this authorization to be used.

Patient's/Patient's Representative's Signature

Witness Signature

Date

Date

Printed Patient's or Representative's Name

Representative's relationship to Patient

Consent to Treatment

I hereby agree to and give consent to the physicians, healthcare providers, associates, and consultants of University Specialty Clinics – _____, and residents of affiliated institution, Palmetto Health, to diagnose and treat me. I consent to any and all treatment including, but not limited to, physical examinations, psychological examinations, x-rays, laboratory procedures, and other procedures related to routine diagnosis and treatment as determined appropriate by the practice's physicians, healthcare providers, associates, consultants and residents.

I give permission to share my electronic medical record among my healthcare providers and obtain medication history through a Provider Health Information Exchange (HIE). The University Specialty Clinics will abide by state and federal law regarding the availability to and access by the other medical providers of any sensitive information, such as behavioral health, substance abuse treatment, sexual abuse, genetic test results, HIV/AIDS status and adoption records. **I MAY OPT OUT OF THE HIE BY COMPLETING THE OPT- OUT FORM AND CONTINUE TO RECEIVE CARE.**

Patient's/Patient's Representative's Signature

Witness Signature

Date

Date

Printed Patient's or Representative's Name

Representative's relationship to Patient



University of South Carolina
School of Medicine Educational Trust
dba University Specialty Clinics

FINANCIAL POLICY

Credit is extended to those patients who need it. However, our policy is
CREDIT ARRANGEMENTS MUST BE MADE BEFORE SERVICES RENDERED

By making arrangements in advance for time payment and keeping your account current, you can avoid the risk of future credit problems with this office.

INSURANCE

Payment of medical fees is the responsibility of the patient. Your insurance company accepts your premium and is responsible to you for reimbursement. We will furnish you with enough information and assistance to file claims BUT we cannot be responsible for collecting your insurance payments. We will allow 45 days for your insurance company to pay assigned claims at which time we will hold you the patient responsible for payment of the account. All co-payments must be made at the time services are rendered. No exceptions.

Patient Initials: _____

UNIVERSITY SPECIALTY CLINICS® 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.

At University of South Carolina, School of Medicine, University Specialty Clinics, 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 University Specialty Clinics. 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.

◆ **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 University Specialty Clinics 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 University Specialty Clinics. 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 University Specialty Clinics, 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 University Specialty Clinics.

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 University Specialty Clinics. 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 University Specialty Clinics, 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, University Specialty Clinics 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.

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.

◆ **Complaint process**

If you believe that your privacy rights have been violated by us, you may complain in writing to the Privacy Officer of University Specialty Clinics at 15 Medical Park, Suite 200, Columbia, SC 29203, phone number (803) 255-3454; 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. University Specialty Clinics considers the privacy of your protected health information an important part of your health care.

◆ **Effective date of Notice**

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 University Specialty Clinics' Web site, <http://specialtyclinics.med.sc.edu/privacy.asp>.



University Specialty Clinics Notice of Privacy Practices

By signing below, I state that I have been given my own copy of the University Specialty Clinics' Notice of Privacy Practices, effective date 4/14/03.

Printed Name of Patient

Signature of Patient

Date

OR

Printed Name of Patient's Representative

Signature of Patient's Representative's

Date

Description of Authority to Act on Behalf of Patient

Patient's Name: _____

Date of Birth: _____

Last Four Digits of Patient's SSN: _____

Communication with Friends, Family, or Others Involved in Your Care

If you are present and do not object, University Specialty Clinics 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 University of South Carolina School of Medicine, 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 University Of South Carolina School Of Medicine; 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. University Specialty Clinics 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.

Name of Family Member, Friend, or Other Person Involved in Patient's Care or Payment for Care	Relationship to Patient/Involvement with Patient's Care or Payment for Care

Signature of Patient or Patient's Legally Qualified Representative

Date of Signature

Printed Name

Relationship to Patient if not the Patient

Call (803) 799-5022 with any questions on directions

Chapin, Irmo, Newberry on I-26

- From I-26 follow I-126 into Columbia & then take **Elmwood Avenue** into Columbia.
- Follow Elmwood until it “dead ends” at **Bull Street**.
- Turn Left on **Bull Street** and then turn right at the third light (**Harden Street**).
- Go to front entrance of Palmetto Health Richland Hospital and turn left.
- Make the first left and you will be looking at **One Medical Park**. A gated parking lot is available to left of the building.
- Enter front of building & take elevator to the 3rd floor, Suite 300.

Charleston, Orangeburg on I-26

- Take I-77 toward Charlotte, then I-20 toward Augusta, then 277 to **Downtown Columbia**. 277 ends at **Bull Street**.
- Turn Left on **Bull Street** and then turn right at the third light (**Harden Street**).
- Go to front entrance of Palmetto Health Richland Hospital and turn left.
- Make first left and you will be looking at **One Medical Park**. A gated parking lot is available to the left of the building

Lugoff/Elgin, Florence on I-20

- Take I-20 to 277 **Downtown Columbia** exit, 277 ends at **Bull Street**.
- Turn left at the light onto **Harden Street** (CVS Drugstore on the corner).
- Go to front entrance of Palmetto Health Richland Hospital and turn left.
- Make first left and you will be looking at **One Medical Park**. A gated parking lot is available to the left of the building

Blythewood, Charlotte, Winnsboro on I-77

- Take 277 to **Downtown Columbia**. 277 ends at **Bull Street**.
- Turn left at the light on **Harden Street** (CVS Drugstore on the corner).
- Go to front entrance of the Palmetto Health Richland Hospital and turn left.
- Make first left and you will be looking at **One Medical Park**. A gated parking lot is available to the left of the building.

In Town

- Take **Bull Street**, going away from downtown, to **Harden Street** and turn left.
- ** From **Forest Acres** area going toward downtown, turn right on Harden Street.
- Go to front entrance of Palmetto Health Richland Hospital and turn right.
- Make first left and you will be looking at **One Medical Park**. A gated parking lot is available to the left of the building

Palmetto Health Richland Campus



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|---|---|
| <ul style="list-style-type: none"> 1 - 1 Medical Park 2 - 2 Medical Park — University Specialty Clinics 3 - 3 Medical Park 4 - 4 Medical Park — SC Eye Institute 5 - 5 Medical Park — Palmetto Health Richland CHILDREN'S HOSPITAL-9TH FLOOR 6 - 6 Medical Park — Palmetto Health Heart Hospital 7 - 6 Medical Park
Palmetto Health South Carolina Cancer Center 8 - 8 Medical Park — Columbia Heart & Rehab 9 - 9 Medical Park 10 - 10 Medical Park 11 - 11 Medical Park — Richland Springs 12 - Palmetto Health Richland Day Care 13 - Energy Facility 14 - 14 Medical Park 15 - 15 Medical Park 16 - Emergency Room | <ul style="list-style-type: none"> 17 - Health South Rehabilitation Hospital 18 - Caring House 19 - Smith House 20 - Ronald McDonald House 21 - 3201 Colonial — Family Medical Center 22 - The Garden at Palmetto Health Richland 23 - Helen Lynch Memorial & Rose Garden 24 - 1801 Sunset Clinics 25 - Outpatient Surgery Parking Entrance 26 - Helicopter Pad <ul style="list-style-type: none"> P Garage Parking P Parking ■ USC School of Medicine ■ Emergency M Main Entrances |
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