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

patinf2 *Revised 06/03/10*

Epworth Sleepiness Scale

Name: _____ Today's date: _____

Your age (Yrs): _____ Your sex (Male = M, Female = F): _____

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you haven't done some of these things recently try to work out how they would have affected you. Use the following scale to choose the **most appropriate number** for each situation:

0 = would **never** doze
1 = **slight chance** of dozing
2 = **moderate chance** of dozing
3 = **high chance** of dozing

It is important that you answer each question as best you can.

Situation	**Chance of Dozing (0-3)**
Sitting and reading	
Watching TV	
Sitting, inactive in a public place (e.g. a theatre or a meeting)	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon when circumstances permit	
Sitting and talking to someone	
Sitting quietly after a lunch without alcohol	
In a car, while stopped for a few minutes in the traffic	

University of South Carolina Sleep Clinic
(Page 1 of 2)

Please answer the following questions. They will become a strictly confidential part of your medical record

Name: _____ **Date of Birth:** ___/___/____
First Middle Last

Social History/Habits

Height ____feet ___inches
Weight _____ pounds
Age _____years

Marital Status
__Single __ Divorced
__Married __ Widowed

Race ___African-American ___Asian ___Caucasian
___South Sea Islander ___Native-American
___ Other _____

Smoking History
A. Did you ever smoke? ____
B. If yes, how old were you when you started? ____ years
C. Do you still smoke? ___No ___Yes
D. If no, how long ago did you stop? ____ years
E. Total years you smoked ____

Family History of serious Medical Illness or sleep disorders
Father: _____
Mother: _____
Brother(s): _____
Sister(s): _____
Children: _____

Name and address of Primary Care Doctor
Name: _____
Address _____
_____
_____
Phone _____
Fax: _____

Are you allergic to any drugs
____Yes ____No *If yes list them*
_____
_____
_____
_____

Employment
Current Job _____
Have you ever worked shift work?
___ No ___Yes, if yes for how long_____
Any night time shifts ___No ___Yes
Highest Level of Education completed
_____

Alcohol History
- Beer ____bottles/cans per day
- Liquor ____drinks per day
- Binge drinking ___yes ___No
- Drinks per week _____

Caffeine History
- Caffeinated coffee ___ cups per day
- Caffeinated tea ___ cups per day
- Caffeinated cola ___ glasses per day
- Chocolate ____ bars per day
- Hot chocolate ____ cups per day
- Time of day you drink your last caffeinated beverage _____

Recreational drug use _____
_____

Past Medical History

___High Blood Pressure ___Anemia
___Stroke ___Sexual Dysfunction
___Heart attack ___Seizures
___Anxiety ___Depression
___Chronic Pain ___COPD
___Kidney Failure ___Diabetes
___Congestive Heart Failure
___Peripheral vascular disease ___Reflux
___Asthma ___Angina ___Pacemaker
___Valve Disease ___Arthritis
___Irregular Heart Rhythm

COMPLETE OTHER SIDE

Past Hospitalizations:

Reason (surgeries, infections, etc.)	*Hospital*	*Year*

Please list any sleeping pills that you have been prescribed and taken in the past:

List ALL medications you are currently taking:

Medication	*Dose*	*Number of times per day*	*How long?*

Review of Systems: Please circle any recent problems or symptoms:

__Weight loss ___Fatigue ___Weight gain ___Muscle Weakness ___Passing out episodes when laughing or crying

__Hallucinations when falling asleep ___Hallucinations when waking up ___Sleep Talking/Walking____Leg cramps

__Headaches ___Snoring ___Dry Mouth ___Seizures ___Jerking of legs when falling asleep ___Leg/Ankle Swelling

__Creepy crawly feelings in skin ___Depression ___Anxiety ___Shortness of Breath at rest ___Cough ____Chest Pain

__Shortness of breath with movement. ____Wheezing ___Heartburn/Reflux ___ Grinding of Teeth ___ Chronic Pain

__Heart attack ___ Irregular Heartbeat ___ Stroke ___Fever ___Chills __Joint Aches ___Sexual Dysfunction

__Kidney failure ___ Dialysis ___Frequent urination ___Car accident because of being asleep __ Memory Difficulty

__Numbness or tingling in feet/hands

List any other Medical Conditions you think are important: _____

Physician Attestation: This history was reviewed with the patient on (date) _____

_____ M.D.
Signature

_____ NP
Signature

SLEEP LOG

Sleep Log: Please Fill Out Using these symbols:

↓ Lights out or in bed trying to sleep — Asleep — ↑ Lights on or out of bed — C Coffee, tea, other caffeine containing beverages

NAME: _____

Example:

← Fill out in the Evening → | **← FILL OUT IN THE MORNING →**

Day Date	Sleeping aid, Alcohol, Medicines	Daytime Fatigue
12/12 Tues	Ambien, Beer	Hi Med Lo

Went to bed at 11, woke at 2am, back to sleep at 3am, up at 6am

6p	7	8	9	10	11	12a	1	2	3	4	5	6a	7	8	9	10	11	12p	1	2	3	4	5	6a
					↓	—	—	↑	↓	—	—	↑		C	C	C								

Sleep Quality: (Poor) Med Good

Your Sleep Log:

← Fill out in the Evening → | **← FILL OUT IN THE MORNING →**

Day Date	Sleeping aid, Alcohol, Medicines	Daytime Fatigue	Sleep Quality
_____	_____	Hi Med Lo	Poor Med Good
_____	_____	Hi Med Lo	Poor Med Good
_____	_____	Hi Med Lo	Poor Med Good
_____	_____	Hi Med Lo	Poor Med Good
_____	_____	Hi Med Lo	Poor Med Good
_____	_____	Hi Med Lo	Poor Med Good
_____	_____	Hi Med Lo	Poor Med Good

6p	7	8	9	10	11	12a	1	2	3	4	5	6a	7	8	9	10	11	12p	1	2	3	4	5	6p

Berlin Questionnaire

1. Complete the following:

height _____ age_____

weight _____ male/female ____

2. Do you snore?

- ☐ yes
- ☐ no
- ☐ don't know

If you snore:

3. Your snoring is?

- ☐ slightly louder than breathing
- ☐ as loud as talking
- ☐ louder than talking
- ☐ very loud. Can be heard in adjacent rooms.

4. How often do you snore?

- ☐ nearly every day
- ☐ 3-4 times a week
- ☐ 1-2 times a week
- ☐ 1-2 times a month
- ☐ never or nearly never

5. Has your snoring ever bothered other people?

- ☐ yes
- ☐ no

6. Has anyone noticed that you quit breathing during your sleep?

- ☐ nearly every day
- ☐ 3-4 times a week
- ☐ 1-2 times a week
- ☐ 1-2 times a month
- ☐ never or nearly never

7. How often do you feel tired or fatigued after your sleep?

- ☐ nearly every day
- ☐ 3-4 times a week
- ☐ 1-2 times a week
- ☐ 1-2 times a month
- ☐ never or nearly never

8. During your waketime, do you feel tired, fatigued or not up to par?

- ☐ nearly every day
- ☐ 3-4 times a week
- ☐ 1-2 times a week
- ☐ 1-2 times a month
- ☐ never or nearly never

9. Have you ever nodded off or fallen asleep while driving a vehicle?

- ☐ yes
- ☐ no

If yes, how often does it occur?

- ☐ nearly every day
- ☐ 3-4 times a week
- ☐ 1-2 times a week
- ☐ 1-2 times a month
- ☐ never or nearly never

10. Do you have high blood pressure?

- ☐ yes
- ☐ no
- ☐ don't know

Scoring Categories:

Category 1 is positive ☐

Category 2 is positive ☐

Category 3 is positive ☐

Name _____

Address _____

_____

USC PULMONARY PATIENT QUESTIONAIRE

(Please complete prior to your office visit)

Name: _____ Age: _____ Date: _____

Reason for Visit: _____ Referring MD: _____

SYMPTOMS: Please check all current symptoms

□ Cough	□ Fever	□ Shortness of breath at rest
□ Sputum production	□ Chills	□ Shortness of breath with exertion
□ Coughing up blood	□ Night Sweats	□ Sleep on several pillows or in a chair
□ Wheezing	□ Leg swelling	□ Stop breathing while sleeping
□ Sinus Drainage	□Weight Loss	□ Waking up short of breath
□ Sore Throat	□Chest pain	

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
❑ Asthma	❑ Anemia	
❑ Emphysema	❑ Sickle Cell Disease	
❑ Tuberculosis	❑ High Blood Pressure	
❑ Allergies	❑ Hypo/Hyperthyroidism	
❑ Sarcoidosis	❑ Migraine Headaches	
❑ Sleep Apnea	❑ Seizures	
❑ Heart Failure	❑ HIV	
❑ Heart Attack	❑ Stroke	
❑ Hypertension	❑ Mental illness_____	
❑ Diabetes	❑ Glaucoma	
❑ Stomach Ulcer	❑ Cancer or Leukemia	
❑ Liver Disease	Type:_____	
❑ Arthritis	❑ Other:_____	
❑ Gout	_____	
❑ Kidney Stones	_____	
❑ Kidney Failure	_____	
	_____	

SURGICAL HISTORY:

Surgery:_____Year:_____	Surgery:_____Year:_____
Surgery:_____Year:_____	Surgery:_____Year:_____

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

Occupation: Type of work you have done in the past:

_____

□ Unemployed □ Retired □Disabled

Marital Status: □ Married □ Single □ Widowed
□ Separated □ Divorced

Tobacco Use: □ Never □ Current
□ Quit □Age you quit:_____
Type: □ Cigars □ Pipe □ Dip □Cigarettes
Age you started:_____ # packs/day_____
# of Years smoked:_____

Exposed to: □ Second hand smoke □ Asbestos
□ Chemical fumes □ Radiation □ Mining

Alcohol Use: □ Never □Occasionally (__drinks per __)
Daily □ Quit **Type**: □ Beer □ Wine □ Liquor

Drug Use:□ Never □ Occasionally □ Daily
Types:_____

Exercise: □Regularly □ Occasionally (____ per ____)
□ Rarely

FAMILY HISTORY: List any medical problems

Father: _____ Mother:_____	Brother/Sister_____ Grandparents:_____

REVIEW OF SYSTEMS: please check any item which describes recent or ongoing symptoms

General: □ None apply

□ Significant weight loss □ Loss of feeling of well-being □ Fatigue or loss of energy □ Difficulty sleeping
Comment: _____

Eyes: □ None apply

□ Blurred vision □ Double vision □ Seeing spots □ Eye pain □ Need glasses □ Cataract □ Glaucoma
Comment: _____

Ear – Nose – Throat: □ None apply

□ Hearing loss □ Ringing in your ears □ Dizziness □ Sore throat □ Breath odor □ Hoarseness
□ Chronic nasal congestion □ Sinus infections □ Nose bleeds □ Toothaches /Bleeding gums
Comments: _____

Respiratory: □ None apply

□ Shortness of breath □ Cough □ Chest congestion □ Wheezing □ Coughing up blood
□ Choking □ Noisy breathing □ History of pneumonia □ History of or exposure to tuberculosis (TB)
Comment: _____

Cardiovascular: □ None apply

□ Chest pain □ Heart fluttering or racing □ Heart murmur □ Decreased exercise tolerance
□ Awakening due to shortness of breath □ Difficulty breathing when lying down □ Leg swelling
□ Pain in buttocks or legs with exercise □ Sensitivity of hands or feet to temperature changes
Comments: _____

Breast: □ None apply

□ Breast lump □ Breast pain □ Breast cancer
Comment: _____

Gastrointestinal: □ None apply

□ Stomach pain □ Nausea □ Vomiting □ Diarrhea □ Constipation □History of taking diet pills
□ Frequent heartburn/ Indigestion □ Belching or sour taste □ Difficulty swallowing □ Bloating
□ History of hepatitis/ yellow jaundice □ Rectal bleeding □ Rectal pain or irritation □ Hemorrhoids
Comments: _____

Genitourinary (Men only): □ None apply

□ Frequent urination (□ often at night) □ Pain on urination □ Prostate problems

Genitourinary (Women only): □ None apply

□ Frequent urination (□ often at night) □ Frequent urinary infections □ Blood in urine
Comment: _____

Lymphatic / Hematologic: □ None apply

□ Unusual lymph node swelling □ Painful lymph nodes □ History of cancer type:_____
□ History of anemia □ Blood clots □ Bruise easily □ Unusual bleeding
Comment: _____

Musculoskeletal: □ None apply

□ Limb or joint pain □ Limb or joint swelling / stiffness / redness □ Muscle weakness □ Loss of muscle bulk □ Muscle spasms or twitching □ Recurring back pain □ Neck pain □ Back injury □ Neck injury
Comment: _____

Neurologic: □ None apply

□ Seizures □ Tremors □ Unusual clumsiness □ Limb weakness □ Numbness / tingling
□ Stroke □ Passing out □ History of head injury □ Chronic headaches
Comment: _____

Psychologic / Sleep: □ None Apply

□ Lapse in memory □ confusion □ Difficulty concentrating □ Depression □ Mood swings
□ History of mental illness □ History of physical or mental abuse □ Snoring □ Daytime sleepiness
Comment: _____

Endocrine: □ None apply

Unexpected changes in: Tolerance to heat □ Tolerance to cold □ Unusual thirst
Comment: _____

Allergy / Immunology: □ None apply

□ Seasonal allergies □ Frequent or unusual infections (ie. Bronchitis)
□ Sensitivity to specific items: _____

Skin: □ None apply

□ Itching □ Rash □ Unusual dryness □ Changes in hair □ Changes in pigmentation
Comment: _____

MD or NP Signature: **Date:**

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

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 payers.
(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

Revised 2/2/2015

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: _____

Effective Date 4/14/03

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

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

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
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
P	Garage Parking
P	Parking
	USC School of Medicine
	Emergency
M	Main Entrances