



122 S. Goose Creek Blvd, Ste B
Goose Creek, SC 29445
P: 843.553.2211 F: 843.553.2210

Patient Information Checklist

(_____)Practice Contact Information (See Separate Insert)

(_____)Patient Missed Appointment Policy (See Separate Insert)

(_____)Patient Bill of Rights and Responsibilities (See Separate Insert)

(_____)HIPAA Privacy Notice (See Separate Insert)

(_____)Medicare Supplier Standard, may not be applicable to all insured patients. (See Separate Insert)

(_____)Acceptance of Services

- I understand that by signing this agreement, I authorize provision of products and/or services to me by Advantage Healthcare of Charleston. I also understand that the products and services provided are prescribed by my physician and that it is necessary that I remain under the supervision of my attending physician during the course of my care.

(_____)Consent for Use or Disclosure of Health Information (See Separate Insert)

- I hereby authorize release to Advantage Healthcare of Charleston any and all of my medical records pertaining to my medical history, services rendered, or treatments received from my physician(s) or hospital. In order to process insurance claims, I also hereby authorize Advantage Healthcare of Charleston to furnish to my insurance carrier(s), any medical history, services rendered, or treatment needed.

(_____)Assignment of Benefits

- I consent to and authorize that payment of benefits for healthcare related services are made to Advantage Healthcare of Charleston. This consent specifically authorizes AHCC to release Patient Health Information (PHI) to insurers, governmental agencies, and their agents for billing purposes and determination of benefits. I assign any benefits payable for physician services to the physician or organization furnishing the services. The terms of the Assignment of Benefits will be until final payments are made for any and all services. If and when there are changes to my insurance plans, I will notify AHCC and sign a new Assignment or Non-Assignment of Insurance Benefits Policy.

(_____)Financial Office Policies (See Separate Insert)

(_____)Patient’s Right to File a Grievance or Complaint (See Separate Insert)

By initialing beside each item above, you agree that the information was provided and reviewed with you during your initial appointment. By signing below you agree to all of the terms provided in full and understand that if you have any questions in regards to the information provided these questions should be cleared up before signing this document. Once the document is signed Advantage Healthcare of Charleston recognizes this as you having full knowledge of the agreements and are in agreement with them all.

Patient Name (Printed)

Patient Name (Signature)

Date

AHC Staff Member (Signature)

Date



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CONTACT INFORMATION

Physical & Mailing Address:

122 S. Goose Creek Blvd., STE B
Goose Creek, SC 29445

Contact Numbers:

Office: 843.553.2211
Fax: 843.553.2210

Hours of Operation:

Day	Morning Hours	Lunch	Afternoon Hours
MONDAY	8:00am – 1:00pm	1:00pm – 3:00pm	3:00pm – 6:00pm
TUESDAY			2:30pm – 7:00pm
WEDNESDAY	8:00am – 1:00pm	1:00pm – 3:00pm	3:00pm – 6:00pm
THURSDAY			2:30pm – 7:00pm
FRIDAY	8:00am – 1:00pm		
SATURDAY	Closed		
SUNDAY	Closed		

After Hours:

Advantage Healthcare of Charleston **DOES NOT** have an afterhour's answering service. Any and all messages will be returned the next shift or the next business day.

In case of an Emergency:

Dial 911 or go to the closest emergency room to you.



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PATIENT MISSED APPOINTMENT POLICY

DEFINITIONS:

- POLICY- a way of managing affairs so as to achieve some purpose.
- APPOINTMENT- a meeting with someone at a certain time and place.
- MISSED- fail to keep, do, or be present at.

It is our wish that each and every one of our patients receive the very best care and service possible. **Your Treatment Program** consists of a specific series of treatments given over a pre-planned time span. If you do not follow this plan, then you will not receive the desired results.

If we did not insist that you meet all your appointments, we would be doing you a disservice and it would be indicative that we did not care. We do not want to do you a disservice and we do care about you and the success of your program here. Therefore, we have a few simple rules that we insist you follow:

1. Meet all your appointments. Arrange the activities in your life so that this can occur.
2. If you become ill, we still want you to come in, because **Treatments** will help you recover.
3. If you are unable to make it in due to an emergency, please call us and let us know so we can reschedule your appointment.
4. With the exceptions of unexpected emergencies, we require that you notify us at least 24 hours in advance as to any appointment changes.
5. **All cancelled or missed appointments must be rescheduled and made up within one week.**
6. There is a \$25.00 fee for missing an appointment without a 24 hour notice.



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PATIENT'S BILL OF RIGHTS

The patient has the right to impartial access to care without regard to race; sex; cultural, national or ethnic origins; economic, educational, religious or political affiliation.

A patient has the right to leave or voluntarily be discharged from care even against the advice of the attending doctor.

The patient has the right not to be subjected to any procedure(s) without voluntary consent or the consent of his/her legally authorized representative.

Information for patients: You have the right to accurate and easily-understood information about your health plan, health care professionals, and health care facilities. If you speak another language, have a physical or mental disability, or just don't understand something, help should be given so you can make informed health care decisions.

Respect and non-discrimination: You have a right to considerate, respectful care from your doctors, health plan representatives, and other health care providers that does not discriminate against you.

Confidentiality (privacy) of health information: You have the right to talk privately with health care providers and to have your health care information protected. You also have the right to read and copy your own medical record. You have the right to ask that your doctor change your record if it is not correct, relevant, or complete.

Complaints and appeals: You have the right to a fair, fast, and objective review of any complaint you have against your health plan, doctors, hospitals or other health care personnel. This includes complaints about waiting times, operating hours, the actions of health care personnel, and the adequacy of health care facilities.

Consumer responsibilities: In a health care system that protects consumer or patients' rights, patients should expect to take on some responsibilities to get well and/or stay well. Patients are expected to do things like treat health care workers and other patients with respect, try to pay their medical bills, and follow the rules and benefits of their health plan coverage. Having patients involved in their care increases the chance of the best possible outcomes and helps support a high quality, cost-conscious health care system.

Other Information: The patient has the right to have a person of his/her sex present during certain physical examinations by a doctor



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HIPAA NOTICE OF PRIVACY PRACTICES STATEMENT

How We Collect Information About You: Advantage Healthcare of Charleston (AHC). AHC and its employees collect data through a variety of means including but not necessarily limited to letters, phone calls, emails, voicemails, and from the submission of personal information on our patient information welcome packet, consent forms, etc.

What We Do Not Do With Your Information: Information about your financial situation and medical conditions and care that you provide to us in writing, via email, on the phone (including information left on voicemails), contained in or attached to applications, or directly or indirectly given to us, is held in strictest confidence. We do not give out, exchange, barter, rent, sell, lend, or disseminate any information about patients who receive services that are considered patient confidential, are restricted by law, or has been specifically restricted by a patient/client in a signed HIPAA consent form.

How We Do Use Your Information: Information is only used as is reasonably necessary to process your insurance or to provide you with health or counseling services which may require communication between AHC and health care providers, medical product or service providers, pharmacies, insurance companies, and other providers necessary to: verify your medical information is accurate; determine the type of medical supplies or any health care services you need including, but not limited to; or to obtain or purchase any type of medical supplies, devices, medications, insurance, etc. If you apply or attempt to apply to receive assistance through us and provide information with the intent or purpose of fraud or that results in either an actual crime of fraud for any reason including willful or un-willful acts of negligence whether intended or not, or in any way demonstrates or indicates attempted fraud, your non-medical information can be given to legal authorities including police, investigators, courts, and/or attorneys or other legal professionals, as well as any other information as permitted by law.

Information We Do Not Collect: We do not use cookies on our website to collect data from our site visitors. We do not collect information about site visitors except for one hit counter on the main index page (www.ahcwellnesscenter.com) that simply records the number of visitors and no other data. We do use some affiliate programs that may or may not capture traffic data through our site. To avoid potential data capture that you visited a diabetes website simply does not click on any of our outside affiliate links.

Limited Right to Use Non-Identifying Personal Information from Biographies, Letters, Notes, and Other Sources: Any pictures, stories, letters, biographies, correspondence, or thank you notes sent to us become the exclusive property of AHC. We reserve the right to use non-identifying information about our clients (those who receive services or goods from or through us) for fundraising and promotional purposes that are directly related to our mission. Clients will not be compensated for use of this information and no identifying information (photos, addresses, phone numbers, contact information, last names or uniquely identifiable names) will be used without client's express advance permission.

You may specifically request that NO information be used whatsoever for promotional purposes, but you must identify any requested restrictions in writing. We respect your right to privacy and assure you no identifying information or photos that you send to us will ever be publicly used without your direct or indirect consent.



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Medicare Supplier Standards

The products and/or services provided to you by Advantage Healthcare of Charleston are subject to the supplier standards contained in the Federal regulations shown at 42 Code of Federal Regulations Section 424.57(c). These standards concern business professional and operational matters (e.g., honoring warranties and hours of operation). The full text of these standards can be obtained from the US Government Printing Office Website. Upon request we will furnish you a written copy of the standards.



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CONSENT FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Our Privacy Pledge

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information.

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for quality control or other operational purposes.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent form (164.520). We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail. Please feel free to call us at any time for a copy of our privacy notices.

Your right to limit uses or disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

Your right to revoke your authorization

You may revoke your consent to us at any time and must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have the right to your health information if they decide to contest any of your claims.

Messages

I acknowledge that it is the policy of Advantage Healthcare of Charleston to leave reminder messages on my answering machine or with another person in my home. I may make a request of an alternative means of communication (within reason) in writing.

I acknowledge that if I should have a problem or question in regards to my rights that I may speak with the office manager about my concerns.



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FINANCIAL OFFICE POLICIES

1. All patients are on a cash basis until our staff can verify all insurance coverage(s).
2. Your insurance will be verified promptly and will be reviewed with you if applicable.
3. After coverage and deductible are verified, this office may accept assignment on most policies provided the insured/patient signs an appropriate statement of benefits and/or a lien authorizing payment to be sent to the doctor.
4. Waiting for the insurance payment is a courtesy and it may be withdrawn under certain circumstances.
5. As a patient, it is your responsibility to take care of the co-payment and deductible (usually a percent or fixed dollar amount) and any non-covered services on a monthly basis. This office may make payment arrangements on an individual basis. Any such plan or arrangements will be discussed during your report of findings.
6. This office does not warrant or guarantee that your insurance company will pay, nor does this office promise that an insurance company will or should pay the fees charged. Insurance policies are an arrangement between the insurance carrier and the patient/insured.
7. Any service not covered or coverage reductions by your insurance carrier will be the patient's responsibility.
8. This office will submit an insurance claim for you. We will not enter into any dispute with your insurance company. If coverage problems arise, you will be expected to assist directly with your insurance adjuster or agent. Any denied or disputed claims will be treated as uncovered.
9. If your account should go to collections for any reason, it will be the patient's responsibility for any court costs, attorney's fees, and or collection costs incurred in collecting the account balance.
10. I authorize the release of any medical or other records or information from my health record. I authorize release of records or information necessary to process any claims.
11. All insurance payments, regardless of which company issues a check first, are applied to your account as long as any balance is due. This means refunds are made only after your balance is completed and cleared with this office.
12. If you receive correspondence of checks from your insurance company, you agree to bring these into our office so that we may determine if any action needs to be taken or if the check is on assignment to this office.
13. If you change insurance companies or employers, you agree to provide this office with the current information immediately.
14. If this office gives you any professional or accounting discount for treatment and you decide to drop out of care then our standard fees will apply.
15. This office accepts MasterCard, Visa, American Express, Discover Card, personal checks and cash.
16. If you have any questions concerning this or any other matter, please speak with the receptionist or our insurance department prior to seeing the doctor.
17. If you stop care and have a financial agreement signed with our office, you will be responsible for any/all charges that you have incurred at our office.
18. Any canceled/returned checks will incur our bank fee as well as an inconvenience fee of \$25.00 for AHC.
19. Any accounts with a balance that is not cleared up within 30 days will incur a late fee of \$25.00 for the first month. Thereafter a fee of 3% will be charge on the balance until the account is paid in full.



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PATIENT'S RIGHT TO FILE A GRIEVANCE OR COMPLAINT

If you find the need to file a complaint against a licensee, or an unlicensed person practicing a profession or occupation that requires a license, you can find an online complaint form.

The complaint form can be found at: www.llr.state.sc.us/POL/Medical/.

The complaining party is responsible for ensuring that all necessary information is included on the form.

In completing the form, the person making the complaint is referred to as the complainant. The individual the complaint is against is referred to as the respondent.

Please state all facts briefly and clearly. Also, include the name, address and phone number of all witnesses, and the specific information they possess to substantiate the complaint. Please include copies of any documents, records, statements or contracts that may assist this agency to conduct an inquiry.

Upon receipt of the complaint, if jurisdiction is established, a thorough investigation is conducted to determine whether a violation has occurred. If a violation of the practice act is found, the respondent may be offered a consent agreement, or a hearing may be held before the Board to resolve the findings of the agency's investigation. Although this action is between the State and the Respondent, the complainant should be prepared to testify, as requested, at a hearing before the Board if the matter has not been otherwise resolved. The complaint will be dismissed by the Board if a violation is not found or the case does not present evidence that would sustain a legal procedure.

If you have any questions regarding the filling out of this form or do not have access to the internet, please contact South Carolina Department of Labor, Licensing and Regulation at: (803) 896-4500.