Patient Policies & Guidelines

Thrive
Family Medicine
(864) 412 -2777
ThriveFamilyMedicine.com

Welcome.

OUR GOAL IS TO PROVIDE HIGH QUALITY, COMPASSIONATE CARE. IN ORDER TO ACHIEVE THIS GOAL, WE HAVE ESTABLISHED THE FOLLOWING SET OF POLICIES.

Clinical Policies

1. Please bring all medications, or a current list of your medications, and a copy of your insurance formulary to your appointments so that we can prescribe effective, safe, and affordable medications for you.
2. Please arrive 10 minutes prior to your appointment if you are an established patient and 30 minutes prior if a new patient. This allows your provider to see you at your scheduled appointment time. You may be asked to reschedule if late for an appointment.
3. Please call the office to schedule an appointment if you have an acute problem. We can typically see you on the day of your call (or at least the following day) and help you avoid an urgent care visit.
4. Appointments may be scheduled, rescheduled, or canceled by calling our office or using our online portal system.
5. Multiple no-shows or late cancellations / reschedules for appointments will result in termination as a patient.
6. Medications will be refilled during office hours only. Please let us know if refills are needed at your appointments. Refills requested outside of an office visit may incur a $25 fee. If your chronic medications are out of refills it is likely time for an appointment with a provider.
7. Please allow 24 hours for responses to questions you may have outside of office visits. We are usually not able to address questions/requests until lunch or after all patients for the day are seen. Please avoid leaving multiple messages for the same request or question.
8. Acute and chronic health problems may not be able to be addressed at a single office visit. If you have multiple issues, several visits may be required to meet your health needs. This helps us provide quality patient care and allows us to stay on time for all scheduled appointments.
9. A complete physical is considered a preventative visit at which we update your medical history, perform a thorough physical exam, and recommend appropriate labs and screening tests based on your age and history. Acute problems/chronic medical issues are typically not addressed at this visit. We recommend scheduling a separate appointment to allow time to adequately address chronic or acute medical issues. If both a preventative and a problem visit are performed at the same visit, the patient will be responsible for the balance not paid by their insurer.
10. Sports, camp, and college physicals are often not covered by insurers. Most, however, will cover preventative visits and well checks. Please bring required forms and immunization records to the visit and we will gladly complete them.

CONTINUED

11. Letters and form completion (FMLA, Disability, etc) outside of an office visit will incur a $25 fee not billable to insurance.

Financial Policies

1. Patients are expected to pay for co-pays, deductibles, and co-insurances and past balances at the time of service. Any overdue accounts that go beyond 60 days will be turned over to an outside collections agency. All collection agency fees, including but not limited to, submission fees and percent of debt fees (up to 50%) will become patient responsibility.
2. Please notify the office at least 24 hours prior to your appointment if you need to cancel or reschedule. Failure to cancel or reschedule appointments with at least 24 hours notice will incur a fee of $40 for regular appointments or $60 for procedures, ultrasounds, ECHOS, physicals, or new patient visits.
3. We accept credit cards (Visa, Mastercard, American Express, and Discover), cash, and checks for account balances. A $35 fee will be charged for any checks returned / with insufficient funds.

I authorize Thrive Family Medicine

- to file insurance claims on my behalf for services rendered and I assign my insurance benefits to be paid directly to Thrive Family Medicine
- to release medical information to process my claim(s)
- to obtain/have access to my medication history
- to obtain/have access to health information exchange

Patient Signature (or Legal Representative) _____ Date _____

Patient Name _____ Date of Birth _____

Thank you for choosing us.

We trust that you will find your experience at Thrive Family Medicine positive and satisfying.

Patient Registration Form

(PLEASE COMPLETE ALL SECTIONS)

Thrive Family Medicine
(864) 412 -2777
ThriveFamilyMedicine.com

Date _____ Provider Being Seen: ☐ Lindsey Cecil, MD ☐ Stephanie Weir, ANP ☐ James Hudson, MD ☐ Brittany Barham, NP

PATIENT INFORMATION

Patient Name (LAST, FIRST, MI) (nickname, if applicable) SS#

Patient Address (Street, Apt. #; City, State, and Zip)

Sex DOB (mm/dd/yy) Mobile # Work # Other # (circle preferred)

Is it ok to leave a message with medical or billing information on your preferred phone? ☐ Yes ☐ No

For appointments or medical information, I consent to (select all that apply): ☐ Phone ☐ Text ☐ Email

Patient Signature (or Legal Representative) Date

Email address for creating a secure Patient Portal account: _____

MEANINGFUL USE CRITERIA (required for gov't reporting purposes)

Do you need an interpreter? ☐ Yes ☐ No Preferred Language: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Relationship

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic

Race: ☐ White ☐ Black ☐ Asian ☐ Hispanic ☐ More than 1 race ☐ Other _____

EMPLOYER INFORMATION

Employed: ☐ N/A ☐ Full-Time ☐ Part-Time **Profession:** _____

Employer Name Employer Address Employer Phone #

Student: ☐ N/A ☐ Full-Time ☐ Part-Time **Retired:** ☐ N/A ☐ Yes **Disabled?:** ☐ N/A ☐ Yes

CONTINUED

GENERAL INFORMATION

Emergency Contact Name | Relationship | Work # | Home/Mobile #

Local Pharmacy (Name, Location/Address, Phone)

Mail Pharmacy (Name, Location/Address, Phone)

PERSON RESPONSIBLE FOR BILL (only if different than above)

☐ Same As Patient Information

Name (LAST, FIRST, MI) | Nickname (if applicable) | SS#

Address (Street, Apt. #; City, State, and Zip)

Sex | DOB (mm/dd/yy) | Mobile # | Work # | Other # (circle preferred)

INSURANCE INFORMATION (Must be information for the person that the insurance is purchased through)

If you have your insurance card(s) with you and you are the primary policy holder, feel free to skip this part. Otherwise, all fields marked marked below with * are required.

PRIMARY Insurance Company

ID/Policy Number

Group Number

***Name of Insured / Cardholder**

***Insured's Social SS#**

***Sex** | ***Insured's DOB**

Employer of Insured | Phone #

***Patient Relationship To Insured (self, child, spouse)**

Office Copay/Coinsurance/Deductible

NOTE: We will NOT file any Medicaid Policies as Secondary Coverage

SECONDARY Insurance Company

If Medicare, Please Provide Reason

ID/Policy Number

Group Number

***Name of Insured / Cardholder**

***Insured's Social SS#**

***Sex** | ***Insured's DOB**

Employer of Insured | Phone #

***Patient Relationship To Insured (self, child, spouse)**

Office Copay/Coinsurance/Deductible

HIPAA Notice of Privacy Practices

Thrive
Family Medicine
(864) 412 -2777
ThriveFamilyMedicine.com

This Notice of Privacy Practices is NOT an authorization. This Notice of Privacy Practices describes how we, our Business Associates and their subcontractors, may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

Uses & Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice and any other use required by law.

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

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

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

We may use or disclose your protected health information the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

Uses and Disclosures That Require Your Authorization

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law. Without your authorization, we are expressly prohibited to use or disclose your protected health information for marketing purposes. We may not sell your protected health information without your authorization. We may not use or disclose most psychotherapy notes contained in your protected health information. We will not use or disclose any of your protected health information that contains genetic information that will be used for underwriting purposes. You may revoke the authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

CONTINUED

Your Rights

The following are statements of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information (fees may apply) - Pursuant to your written request, you have the right to inspect or copy your protected health information whether in paper or electronic format. Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

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

You have the right to request to receive confidential communications – You have the right to request confidential communication from us by alternative means or at an alternative location.

You have the right to request an amendment to your protected health information - If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures - You have the right to receive an accounting of disclosures, paper or electronic, except for disclosures; pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of the request.

You have the right to receive notice of a breach - We will notify you if your unsecured protected health information has been breached.

You have the right to obtain a paper copy of this notice from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

Complaints

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

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number. Please sign the accompanying "Acknowledgment" form. Please note that by signing the Acknowledgment form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of privacy practices.

Didii Edwards
HIPAA Compliance Officer

864-412-2777
didiiedwards@thrivefamilymedicine.com

CONTINUED

I hereby acknowledge receipt of HIPAA Notice of Privacy Practices from Thrive Family Medicine.

Patient Name (printed)	DOB
Patient Signature (or Legal Representative)	Date