Truesdale Medical Center No-Show/ Late Cancellation Policy

When our office schedules your appointment, we reserve a dedicated time slot just for you. Our policy is that if you must reschedule your appointment that you must provide us with at least 24 hours' notice. This courtesy makes it possible to give your reserved time slot to another patient in need.

***Late Arrival: patients arriving 10 minutes late for their appointment will be asked to reschedule to avoid impacting other patients' wait times.**

*Repeated cancellations or missed appointments will result in loss of future appointment privileges and possible dismissal from the practice.

All Medical Appointments: 3 Missed appointments within a 6-month time frame.

After 2 missed or cancelled appointments within a 24-hour time frame, a warning will be given to the patient, if a 3rd appointment is missed or cancelled, the patient will lose scheduling privileges.

LOSS OF SCHEDULING PRIVILEGES

Patient will be verbally notified of TMC's No Show Process indicating they will be UNABLE to be placed on the Providers schedule but instead must call our office that morning to see if he/she can be worked into the Providers schedule which could result in extended wait times.

To return to the normal scheduling process, a chronic no-show patient must keep THREE consecutive appointments. Once those appointments are made and kept, they will be able to return to TMC's normal scheduling policy.

I have read the above Appointment Policy and have signed to ensure my understanding of this policy.

Signature _____ Date _____

PRINT NAME_____

Truesdale Medical Center
5064 Rivers Avenue
North Charleston, SC 29406
truesdalemedical.org
O (843) 266-3870
F (843) 225-3674

FINANCIAL POLICY

We are committed to meeting your healthcare needs. Our goal is to keep your insurance or other financial arrangements as simple as possible. In order to accomplish this in a cost effective manner, we ask that you adhere to the following guidelines.

- I agree to furnish ***Truesdale Medical Center*** with a copy of my current health insurance card(s). I also agree to provide an explanation of benefits and/or claim form(s) from my insurance company, when applicable.
- I authorize the release of medical information necessary to process my insurance claim and I assign insurance benefits to ***Truesdale Medical Center*** for services provided to me by ***Truesdale Medical Center*** heath care providers.
- I understand that I will be responsible for payment of any deductible and co-payment/ co-insurance as determined by your contract with your insurance carrier. We expect these payments at time of service, as required by my insurance company before being seen by a ***Truesdale Medical Center*** heath care provider.
- I agree that I will be responsible for balances applied to my account that are not covered by my health insurance plan.
- I understand that my account will be charged $75 when a check I presented for payment is returned and marked "non-sufficient funds" (NSF). Returned checks over $500 will be assessed a fee of 10% of the amount of the check.
- I understand that ***Truesdale Medical Center*** will bill my health insurance company and will refund any overpayment on my account to the appropriate party (i.e., insurance company, patient).
- I understand that ***Truesdale Medical Center*** allows 30 days for the processing of my claim by the insurance company. In the event the practice does not receive reimbursement within 45 days, they will contact my insurance company regarding the claim; I will be notified if they do not receive a response.
- In the event I am unable to pay my responsibility in full, I will contact the office to discuss financial arrangements.
- Uninsured patients will pay a $100 per office consultation plus any additional charges that may be included in your visit.
- If you plan to pay privately for your services, please be advised that it is the policy of ***Truesdale Medical Center*** to collect payment in full at the time of service. If you are unable to make payment in full at the time of service, your appointment will be rescheduled to a more convenient time.
- I accept full financial responsibility for all charges, insurance balances, self-pay balances and other fees that may not be covered by my medical plan.
- I consent to the release of my protected healthcare information to credit card companies, banks and financing companies in the event a charge is disputed.

I acknowledge that I have received a copy of this financial policy. I agree to read this document and comply with the terms set forth for services rendered by ***Truesdale Medical Center.***

_____ _____

Patient Signature (Guarantor) Date

_____ _____

Witness Date

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General Consent and Disclosure

The information in this consent form is given so that you will be better informed about the health care services you will receive. After you are sure you understand the information which will be given about the services and if you agree to receive the services, you must sign this form to indicate that you understand and consent to the services.

GENERAL CONSENT: I give permission to Truesdale Medical Center, its designated staff, and other medical personnel providing services under their sponsorship to perform physical assessments or examinations, conduct laboratory or other tests, give injections, medications, and other treatments, and render other health services to the patient identified on this form. Behavioral Health treatment of a minor cannot be provided without consent of a legal authorized representative.

INFORMED CONSENT: In addition to the above general consent, I give permission to Truesdale Medical Center and their staff to perform a search through electronic medical records of my prescribed medications.

INFORMED UNDERSTANDING: I understand that there are certain hazards and risks connected with all forms of treatment, and that no warranty or guarantee has been made to me as to the result of cure from care and treatment provided.

RELEASE OF INFORMATION: I further understand that all Medical Records, Behavioral Health/Substance Abuse Records, and Social Service Records may be released to representatives of the United States Department of Health and Human Services and to representatives of programs or projects funded by this Department and other funding services sources for the purposes of determining contract compliance with Federal/State law and regulations.

QUESTIONS: I certify that this form has been fully explained to me, that any blank lines have been filled in, and that any questions I have had about the services have been answered to my satisfaction. I further certify that I have read the Patient and Clinic Rights and Responsibilities and may request a copy of this document.

EXPIRATION: I understand that this consent is valid and remains in effect as long as I am a patient of Truesdale Medical Center, until I withdraw my consent, or until Truesdale Medical Center changes its services and asks me to complete a new consent form.

SIGNATURES: Fill blank lines with NA if not applicable.

Patient Name: _____ DOB: _____ Sex: _____

Patient Signature: _____

Person Authorized to Consent (if not patient): _____ Relationship: _____

Signature: _____ Date: _____

Truesdale Medical Center

5064 Rivers Avenue
North Charleston, SC 29405
truesdalemedical.org
palmettocare.org

TMC Office - 843-266-3870
PCC Office - 843-747-2273
Fax - 843-225-3674

Palmetto Community Care

HIPAA-ACKNOWLEDGEMENT OF RECEIPT

Notice of Privacy Practices

Printed Patient Name: _____

Patient Birth Date: _____

We at Truesdale Medical Center and Palmetto Community Care are required by law to maintain the privacy of and provide individuals with the attached Notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to the Notice, please ask to speak with our HIPAA Compliance Officer in person or by phone at 843-747-2273. A copy of the Notice is available upon request.

I hereby acknowledge that I have reviewed the HIPAA Notice of Privacy Practice document.

_____ _____

Signature of patient or patient's representative/parent Date

_____

Printed name of patient or patient's representative/parent

_____

Relationship to patient

Truesdale Medical Center
5064 Rivers Avenue
North Charleston, SC 29406
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Truesdale Medical Center

Effective October 15, 2018 Revised : January 30, 2024

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.

Truesdale Medical Center is owned by Palmetto Community Care. Because of their affiliation, both share private access to all patient medical information.

Truesdale Medical Center uses health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive. Your health information is contained in a medical record that is the physical property of Truesdale Medical Center.

How Truesdale Medical Center May Use or Disclose Your Health Information

For Treatment. Truesdale Medical Center may use your health information to provide you with medical treatment or services. For example, information obtained by a health care provider, such as a physician, nurse, or other person providing health services to you, will record information in your record that is related to your treatment. This information is necessary for health care providers to determine what treatment you should receive. Health care providers will also record actions taken by them in the course of your treatment and note how you respond to the actions.

For Referrals to Other Providers and Health Care Entities: Truesdale Medical Center may use and disclose your health information to promote continuity of care with other healthcare and enabling services.

For Payment. Truesdale Medical Center may use and disclose your health information to others for purposes of receiving payment for treatment and services that you receive. For example, a bill may be sent to you or a third-party payor, such as an insurance company or health plan. The information on the bill may contain information that identifies you, your diagnosis, and treatment or supplies used in the course of treatment.

For Health Care Operations. Truesdale Medical Center may use and disclose health information about you for operational purposes. For example, your health information may be disclosed to members of the medical staff, risk or quality improvement personnel, and others to:

- evaluate the performance of our staff;
- assess the quality of care and outcomes in your cases and similar cases;
- learn how to improve our facilities and services; and
- determine how to continually improve the quality and effectiveness of the health care we provide.

Appointments. Truesdale Medical Center may use your information to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for your Care. Truesdale Medical Center may disclose PHI to a person who is involved in your care or helps pay for your care, such as a family member or friend if you agree, or when given the opportunity, you do not object. Please fill out a confidential communication consent form with the names of those involved in your care. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Business Associate. Truesdale Medical Center may disclose PHI to our business associates to perform certain business functions or provide certain business services to Truesdale Medical Center. All of our business associates and their subcontractors are required to maintain the privacy and confidentiality of your PHI.

Required by law. Truesdale Medical Center may use and disclose information about you as required by law. For example, Truesdale Medical Center may disclose information for the following purposes:

- for judicial and administrative proceedings pursuant to legal authority;
- to report information related to victims of abuse, neglect or domestic violence; and
- to assist law enforcement officials in their law enforcement duties;

Public Health. Your health information may be used or disclosed for public health activities such as assisting public health authorities or other legal authorities to prevent or control disease, injury, or disability, or for other health oversight activities.

Decedents. Health information may be disclosed to funeral directors or coroners to enable them to carry out their lawful duties.

Organ/Tissue Donation. Your health information may be used or disclosed for cadaveric organ, eye or tissue donation purposes.

Research. Truesdale Medical Center may use your health information for research purposes when an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your health information has approved the research.

Health and Safety. Your health information may be disclosed to avert a serious threat to the health or safety of you or any other person pursuant to applicable law.

Government Functions. Your health information may be disclosed for specialized government functions such as protection of public officials or reporting to various branches of the armed services.

Workers' Compensation. Your health information may be used or disclosed in order to comply with laws and regulations related to Workers' Compensation.

Neonatal Testing. Information regarding neonatal testing to detect inborn metabolic errors and hemoglobin apathies may be released only to the parents of the child, the child's physician and the child, when 18 years of age or older.

Picture ID as a form of patient identifier

Truesdale Medical Center uses a picture ID as a patient identifier when using EHR technology. The ID will be acquired via camera or cropping of the picture ID.

Other uses. Other uses and disclosures will be made only with your written authorization and you may revoke the authorization except to the extent Truesdale Medical Center has taken action in reliance on such.

Exception to Use and Disclosure of Your Health Information:
The following are specific uses and disclosures that require your authorization:

- Uses and disclosures of PHI for marketing purposes
- Disclosures that constitute the sale of your PHI
- Most uses of disclosures of your psychotherapy notes

Psychotherapy Notes. Psychotherapy notes are notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during counseling session. Psychotherapy notes are separated from the rest of your medical record and do not include medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and prognosis to date. Truesdale Medical Center may use or disclose psychotherapy notes in the following instances without obtaining authorization:

A. Carry out treatment, payment or healthcare operations
    - use of psychotherapy notes by the originator for treatment
    - use or disclosure by Truesdale Medical Center in training programs in which students, trainees, or practitioners in mental health learn under supervision to practice or improve their skills in group, joint, family, or individual counseling
    - use or disclosure by Truesdale Medical Center to defend itself in a legal action or other proceeding brought by the individual
B. Use or disclosure that is required for the enforcement of the regulations by HHS
C. Use or disclosure that is required by law
D. Use or disclosure if needed for oversight of the creator of the notes (counselor/therapist)
E. Use or disclosure if needed to avert a serious and imminent threat to health and safe

Substance Use Disorder Patient Records. The confidentiality of substance use disorder patient records maintained by Truesdale Medical Center is protected by federal law and regulations. Truesdale Medical Center may not say to a person outside of the practice that a patient attends the practice for substance use disorder nor disclose any information identifying a patient as being a substance use disorder patient unless:

1. The patient consents in writing:
2. The disclosure is allowed by court order;
3. The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or practice/program evaluation.

Violation of the federal law and regulations by a practice is a crime. Suspected violations may be reported to appropriate authorities in accordance with federal regulations.

Federal law and regulations do not protect any information about a crime committed by a patient either at the practice/program or against any person who works for the practice/program or about any threat to commit such a crime.

Federal laws and regulations do not protect any information about suspected child abuse or neglect from being reported under state law to appropriate state or local authorities.

Your Health Information Rights
You have the right to:

- obtain a paper copy of the notice of information practices (this document) upon request;
- inspect and obtain a copy of your paper health record
- obtain electronic copy of PHI in form or format requested if readily producible and to direct Truesdale Medical Center a to transmit a copy to an entity or person you designate, provided that it is made in writing, signed by the individual, clearly identifies the designated person and clearly identifies where the information will be sent.
- request that your health record be amended;
- request communications of your health information by alternative means or at alternative locations; and
- receive an accounting of disclosures made of your health information.

Right to Request Limits on Uses and Disclosures of your PHI- You have the right to request that we limit 1) how we use and disclose your PHI for treatment, payment, and health care operations activities; or 2) our disclosures of PHI to individuals involved in your care or payment for your care. Truesdale Medical Center will consider your request, but is not required to agree to it unless the requested restriction involves a disclosure that is for the purpose of payment or healthcare operations and is not otherwise required by law or the protected health information pertains to a healthcare item or service which has been paid in full other than by the health plan. If we agree to a restriction on other types of disclosures, we will state the agreed restriction in writing and will abide by them, except in emergency situations when the disclosure is for purposes of treatment.

Notice of Breach
Truesdale Medical Center is required to provide patient notification if it discovers a breach of unsecured PHI unless there is a demonstration, based on a risk assessment, that there is a low probability that the PHI has been compromised. You will be notified without reasonable delay and no later than 60 days after discovery of the breach. Such notification will include information about what happened and what can be done to mitigate any harm.

Complaints
You may make a complaint in person on our Privacy Complaint Form or by mail either on our Privacy Complaint Form or in a letter stating the necessary information specified below:
a. The type of violation the complaint involves;
b. A detailed description of the privacy issue;
c. The date the incident or problem occurred, if applicable;
d. The mailing address to which a formal response to the complaint may be sent.

Please mail the complaint to the address below. You may also make a complaint to the Department of Health and Human Services if you believe your privacy rights have been violated. You will not be retaliated against for filing a complaint.

Contact Information
If you have any questions or complaints, please contact the privacy officer below:

Janice Nichols
5064 Rivers Avenue
N. Charleston, SC 29406
843-747-2273

Truesdale Medical Center reserves the right to change its information practices and to make the new provisions effective for all protected health information it maintains. Revised notices will be made available to you by written and posted communications.

TRUESDALE MEDICAL CENTER / PALMETTO COMMUNITY CARE

AUTHORIZATION TO RELEASE/DISCLOSE PROTECTED HEALTH INFORMATION

Information to be released to:

Truesdale Medical Center / Palmetto Community Care
5064 Rives Avenue
N. Charleston, SC 29406
843-266-3870 phone
843-255-3674 fax

Information to be released from:

Name: _____
Address: _____
_____
Phone: _____
Fax: _____

- By initialing the space below, I authorize the following information to be released/disclosed:
  _____ Complete Medical Record

- By initialing the space below, I authorize ONLY the following information to be released/disclosed:
  _____ Office Notes _____ Radiology/Imaging _____ Lab/Pathology _____ Prescription

  _____ Other _____

- By initialing the space below, I authorize the above information released/disclosed to include:
  _____ Treatment of Drug & Alcohol Abuse
  _____ Psychological or Psychiatric Impairments
  _____ Human Immunodeficiency Virus (HIV) & Acquired Immunodeficiency Syndrome (AIDS)

- By initializing below, I certify (declare) the purpose of the release/disclosure is for:
  _____ Medical Review _____ Legal Review _____ Insurance _____ Continuity of Care
  _____ Other _____

I understand that I have a right to revoke this authorization at any time by notifying Truesdale Medical Center in writing. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand that any revocation does not apply to the acceptable and lawful releases under the Notice of Privacy Practices.
I hereby authorize the use or disclosure of my identifiable health information as described above. The facility, its employees, officers and providers are hereby released from any legal responsibility or liability for the release and disclosure of the above information to the extent indicated and authorized herein.

I understand that I may be charged for copies of my records based on Truesdale Medical Center's policy. Current rates apply.

PATIENT NAME:_____ PATIENT PHONE: _____
PLEASE PRINT NAME

SIGNATURE: _____ PATIENT BIRTHDATE: _____
LEGAL GUARDIAN IF MINOR OR LEGAL REPRESENTATIVE

DATE: _____ Date of Expiration: _____

Truesdale Medical Center Intake Form

We'd like to welcome you as a new patient. Please take the time to fill out this form as accurately as possible so we can most appropriately address your health needs.

Please print all responses.

Legal Name: _____ Date of Birth: _____

Preferred Name: _____

Social Security Number: _____
Address: _____ Zip: _____ City: _____
Sex/Gender: Male Female Transgender
Race (e.g., African American, Latino, Asian, Caucasian, etc): _____
Ethnicity: Hispanic Non-Hispanic
Phone Number (___) _____- _____ OK to leave a message? ☐ ☐
Email Address: _____ OK to contact by email: ☐ ☐
Employment Status: Full Time, Part Time, Not Employed, Self Employed, Student, Retired
Pharmacy Name: _____Address: _____
Pharmacy Number: _____
Insurance: _____ ID#: _____
Subscriber: _____ Subscriber Birthdate: _____
Secondary Insurance: _____ID#: _____
Subscriber: _____
Relationship/Marital Status: (e.g., single, married, partnered, living together, divorced)
_____
Name of Your Partner or Spouse: (if applicable) _____
Language Spoken Most Often: _____Do You Need an Interpreter? ☐ ☐

What is your concern for today's visit?

_____
_____
_____

_____ _____
Patient Name Date

_____
Signature of Patient, Parent or Guardian