THIS FORM IS FOR YOUR REVIEW & SIGNATURE. IF TELEHALTH, COMPLETE & RETURN TO FORMS@CHARLESTONPULMONARY.COM

CHARLESTON PULMONARY ASSOCIATES, P.A.
CAROLINA SLEEP SPECIALISTS, P.A.

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Notices, Consents, Policies and Disclosures

We require your consent to collect personal information about you, make available our notice of privacy practices, and ensure you review all our patient policies. Please read this consent for treatment, Financial Policies and Disclosures; and Notice of Privacy Practices form carefully and sign electronically on the pad provided by our registration staff. Your signature states you read and understand all policies, consent for treatment, and acknowledge of receipt of updated notice of privacy practices.

This Medical Practice collects such information for the primary purpose of providing quality health care. We require you to provide us with your personal details and a full medical and medication/prescription history to allow us properly to assess, diagnose, treat, and advise on all your health care needs.

Consent for Treatment

1. I voluntarily consent to any and all health care treatment and diagnostic procedures provided by Charleston Pulmonary Associates, PA & Carolina Sleep Specialists, PA. and its associated physicians, clinicians and other personnel. I am aware that the practice of medicine and other health care professions is not an exact science and I further state that I understand that no guarantee has been or can be made as to the results of the treatments or examinations at Charleston Pulmonary Associates, PA & Carolina Sleep Specialists, PA.
2. I agree to be contacted via email or SMS with information related to my visit, like: a patient portal invitation, telehealth information, post-visit satisfaction survey, appointment or checkup reminders, health tips, or new services that relate to me or my family.
3. I consent to the use and disclosure of my/the patient's protected health information for purposes of obtaining payment for services rendered to me/the patient, treatment and health care operations consistent with the Charleston Pulmonary Associates, PA & Carolina Sleep Specialist, PA Notice of Privacy Practices.
4. I authorize payment of medical benefits to Charleston Pulmonary Associates, PA & Carolina Sleep Specialists, PA. physicians or their designee for services rendered.
5. I give permission to obtain all my medication/prescription history when using an electronic system to process prescriptions for my medical treatment.

The Financial Policy and Disclosure

The Financial Policy and Disclosure is to help us provide the most efficient and reasonable health care services. Therefore, it is necessary for us to have a Financial Policy and Disclosure stating our requirements for payment for services provided to patients. Patients are responsible for the payment of all services provided by Charleston Pulmonary Associates, PA.

Self-Pay Policy

- If you are a self-pay patient, you will be required to pay for the office and/or virtual visit before services are rendered.
- In addition, any remaining balance on your account will be collected before your appointment begins during the checkin process or scheduling process for a telehealth visit.

Insurance Policy

• If you are an insurance patient, it is our policy to file for insurance as a courtesy to you, if we have accurate and complete insurance information.
• If a service is provided that is not covered by your insurance company, you will be the responsible party at the time of service. Non-covered services and supplies may include medical supplies, durable medical equipment, medications, etc.
• If we have not received a payment from your insurance company within the contracted time frame specified by your insurance company's contract with Charleston Pulmonary Associates, PA, you will be responsible for the balance due.
• Deductibles, co-payments, and coinsurance will be collected before services are rendered.
• In special cases, we may need your help in contacting your insurance company for the payment of your services.

Overdue and Credit Balances

• All over-due patient balances may be sent to collections and will be charged a $25 collection fee in addition to the account balance.
• Credit balances under $20 aged over 60 days may be written off.

Divorce or Custody Case Policy

• The parent or guardian who brings the patient into our office will be held financially responsible, regardless of the provisions in the divorce decree, or who has custody, or who has the insurance.

To help in this policy, we ask that you assist us by:

1. Providing us with current and updated information on yourself and your insurance company.
2. Presenting an updated photo identification card and insurance card when changes are made.
3. Making the appropriate payment at the time of service, whether it is a deductible, copay, coinsurance, or for the full amount if you are a Self-Pay Patient.

In order to provide the best medical care, we ask that you do not discuss your account balance or financial aspects with the physician(s) or medical staff. Please discuss any account information with the checkout associate, billing department or front desk staff.

Patient Information Policy

I understand that my treatment will not be conditioned on signing this authorization and that I have the right to refuse to sign this authorization. I understand that information disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I understand that I have the right to revoke this authorization by sending a written notification to our practice. I also understand that a revocation is not effective if the information has already been disclosed but will be effective going forward. I understand that I have the right to inspect or copy the protected health information as described in this document and the practices Privacy Practices. I can do this by written notification.

I understand by signing electronically on the pad my signature will appear on this form in my chart. I further understand the Practice is authorized on my behalf to use my relevant personal health information, acknowledge receipt of updated Notice of Privacy Practices, and I'll adhere to the office policies mentioned above. I am free to withdraw my consent by written notification mailed to the practice (address at top of this page).

Signature:_____ Date: _____

If filling out the form via electronic format, I understand by typing my full name on the signature line, I do hearby attest this information is true, accurate and complete to the best of my knowledge, and I understand this will serve as my e-signature of this form and is the same as if it were signed by hand.

Notice of Privacy Practices
Charleston Pulmonary Associates, PA
Carolina Sleep Specialists, PA

This notice describes how medical information about you may be used, disclosed, and how you can get access to this information. Please review this document carefully.

Patient Health Information (PHI)
Under federal law, your patient health information (PHI) is protected and confidential. Patient health information (PHI) includes information about your symptoms, test results, diagnosis, treatment, and related medical information. Your patient health information (PHI) also includes payment, billing and insurance information. We are committed to protect the privacy of your PHI.

How we use your patient health information (PHI)
IThis Notice of Privacy Practices Notice how we may use within our practice or network and disclose (share outside of our practice or network) your PHI to carry out treatment, payment or health care operations, for administrative purposes, for evaluation of the quality of care, and so forth. We may also share your PHI for other purposes that are permitted or required by law. This Notice also describes your rights to access and control your PHI. Under some circumstances we may be required to use or disclose your PHI without your consent.

Treatment: We will use and disclose your PHI to provide you with medical treatment or services. We may also disclose your PHI to other health care providers who are participating in your treatment, to pharmacists who are filling your prescriptions, to laboratories performing tests, and to family members who are helping with your care, and so forth.

Payment: We will use and disclose your PHI for payment purposes. For example, we may need to obtain authorization from your insurance company before providing certain types of treatment. We will submit bills and maintain records of payments from your health plan. PHI may be shared with the following: billing companies, insurance companies (health plans), government agencies in order to assist with qqualification of benefits, or collection agencies.

Operation: We may ask you to complete a sign in sheet or staff members may ask you the reason for your visit so we may better treat for you. Despite safeguards, it is always possible in a doctor's office that you may learn information regarding other patients or they may inadvertently learn something about you. In all cases, we request our our patients maintain strict confidentiality of PHI.

We may use and disclose your PHI to perform various routine functions (e.9. quality evaluations or records analysis, training students, other health care providers or ancillary staff such as billing personnel, to assist in resolving problems or complaints within the practice). We may use your PHI to contact you to provide information about referrals, for follow-up with lab results, to inquire about your health or for other reasons. We may share your PHI with Business Associates who assist us in preforming routine operational functions (example is our telehealth service (doxy.me), but we will obtain assurances from them to protect your PHI the same as we do.

Special Situations that DO NOT require your permission: We may be required by law to report suspected abuse or neglect, and so on; we may be required to disclose vital statistics, diseases, and similar information to public health authorities; we may be required to disclose information for audits and similar activities, in response to a subpoena or court order, or as required by law enforcement officials. We may release information about you for worker's compensation or similar programs to protect your health or the health of others or for legitimate government needs, for approved medical research, or to certain entities in the case of death. Your PHI may also be shared if you are an inmate or under custody of the law which is necessary for your health or th,, health and safety of other individuals.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose PHI of individuals who are Armed Forces personnel for activities deemed necessary by appropriate military command authorities, for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or to foreign military authority if you are a member of that foreign military services.

In some situations, we may ask for your written authorization before using or disclosing any identifiable health information about you. If you sign an authorization, you can later revoke the authorization.

Individual Rights
You have certain rights with regard to your PHI, for example:
Unless you object, we may share your PHI with friends or family members, or other persons directly identified by you at the level they are involved in your care or payment of services. If you are not present or able to agree/object, the healthcare provider using professional judgment will determine if it is in your best interest to share the information. We may use or disclose PHI to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. We may use or disclose your PHI to an authorized public or private entity to assist in ddisaster relief efforts.

You may request restrictions on certain uses and disclosures of your PHI. We are not required to accept all restrictions. If you pay in full for a treatment or service, you can request that we not share this information with your medical insurance provider. We will make every attempt to accommodate this request and, if we cannot, we will tell you prior to the treatment.

You may ask us to communicate with you confidentially by, for example, sending notices to a special address.

In most cases, you have the right to get a copy of your PHI. There willl be a charge for the copies.

If you believe information in your record is incorrect, or if important information is missing, you have the right to request that we amend the existing information by submitting a written request. You may request a list of instances where we have disclosed PHI about you for reasons other than treatment, payment, or operations. The first request in a 12 month period is free. There will be charges for additional reports.

You have the right to obtain a paper copy of this Notice from us, upon request. We will provide you a copy of this Notice on the first day we treat you at our facility and is posted always in our lobby. In an emergency situation we will give you this Notice soon as possible y ou have the right to receive notification of any breach of your protected health information.

Health Information Exchange (eEXH Summary)
eEXH Summary is our practice's Health Information Exchange (HIE), the electronic sharing of health information between participating providers in a way that ensures the secure exchange of health information to provide care to patients. You have a right to opt-out of HIE participation. If you choose to opt providers will not be able to search for your most recent health information when determiner; treatment. Opting out will not affect your ability to access medical care. If you do not wish to participate in the HIE, you may request a copy of our HIE, Patient Opt out form upon registration or by noting your registrations form.

Our Legal Duty
We are required by law to protect and maintain the privacy of your PHI, to provide this Notice about our legal duties and privacy practices regarding PHI, and to abide by the terms of the Notice currently in effect. We may update or change our privacy practices and policies at any time. Before we make a significant change in our policies, we will change our Notice and post the new Notice in the registration area and lobby. You can also request a copy of our Notice at any time.

If you are concerned about your privacy rights, or if you disagree with a decision we made about your records, you may contact the Privacy Officer listed below. You may also send a written complaint to the U.S. Department of Health and Human Services. You will not be penalized in any way for filing a complaint.

Contact Person
If you have any questions, requests, or complaints, please contact:

Charleston Pulmonary Associates, PA
Attn: Privacy Officer
125 Doughty Street Suite 200
Charleston, SC 29403

HIPAA South Carolina
US DHHS
Atlanta Federal Center
Suite 3B70
61 Forsyth Street
Atlanta, GA 30303 8909