Thank you for choosing Community Medicine Foundation, Inc. for your health care needs.

Enclosed is your new patient registration package. To prevent delays, please have these forms completed when you come in for your appointment.

Appointment Date: _____

Time: _____Doctor: _____

Please arrive at least 30 minutes before your appointment time. If you are late you will have to reschedule.

Please remember to bring the following:

- ♦Insurance Card
- ♦Picture Identification
- ♦Immunization Record (for children)
- ♦All Medications – **Bring ALL Bottles**
- ♦Medicaid or Medicare Card
- ♦Social Security Card
- ♦Birth Certificate (for children)

If you do not have insurance, ALSO bring the following to verify your income and household size:

- ❖ Social Security Card for all household members & Birth Certificate for all children
- ❖ Picture Identification for all adult household members
- ❖ Two current pay-stubs from all household members who are working. If self-employed, bring your last income tax return.
- ❖ You may use your bank statement if you have direct deposit for Social Security, Retirement or Disability.
- ❖ A valid South Carolina ID and a valid utility bill. The bill must contain the name of the patient that has an appointment.
- ❖ SC Unemployment Office located 219 Hampton St, Rock Hill. (803) 328-3881 or visit their website at www.dew.sc.gov.

- **Any patient that does not provide this information on their first visit will automatically become a Self Pay patient.**

If you have any questions, please call 803-325-7744.

If you expect to have laboratory test or blood work done, the night before your appointment, do not eat or drink after midnight.

Your appointment is at the circled location:

North Central	North Central Chester	North Central Pediatric Center
1131 Saluda Street	115 Cestrain Square	225 S Herlong Ave, Suite 250
Rock Hill, SC 29730	Chester, SC 29706	Rock Hill, SC 29732
803-325-7744	803-581-0574	803-325-8742

Payment is required at the time of your visit. For your convenience, we accept cash, debit cards and credit cards.

Revised: March 5, 2015 /brb

COMMUNITY MEDICINE FOUNDATION, INC.

PATIENT INFORMATION

Name: First **Last** **MI** **Date of Birth** / /

Sex: ☐ F ☐ M **Street Address:** **City** **State** **Zip**

Phone (home): ( ) - **Daytime:** ( ) - **Mobile:** ( ) - **Soc. Sec #** - - **Marital Status:** ☐Single ☐Married ☐ Divorced ☐Separated ☐Widowed

Relationship to responsible party: ☐Self ☐Child ☐Spouse ☐Other

Which of the following ethnicities do you feel you belong to?
☐Hispanic
☐Not Hispanic

Pay Range: Insured Pts Only
$0—$10,000 $10,001—$20,000 $20,001—$30,000 $30,001—$40,000 $40,001—$50,000 over $60,000
Please circle the one that best fits your income.

Which of the following race do you feel you belong to?
☐ Asian
☐ Black/African American
☐ White
☐ American Indian/Alaska Native
☐ Native Hawaiian
☐ Pacific Islander
☐ More than one Race

EMAIL ADDRESS:

_____

U.S. Veteran: ☐ Yes ☐ No
Living in Public Housing or Section 8: ☐ Yes ☐ No
Migrant/Seasonal/Agricultural Worker: ☐ Yes ☐ No
Homeless: ☐ Yes ☐ No
Renting Home or Apartment: ☐ Yes ☐ No
Own Home or Apartment: ☐ Yes ☐ No
Temporary: ☐ Yes ☐ No
Other: _____

RESPONSIBLE PARTY INFORMATION (Enter name of person financially responsible for your account)

Name: First **Last** **MI** **Soc. Sec #** - -

Street Address: **City** **State** **Zip**

EMERGENCY INFORMATION

Emergency Contact: **Phone # ( ) -**

INSURANCE INFORMATION

Insurance Company Name: **ID#**

Name of Insured: **Date of Birth** / /

AUTHORIZATION AND ASSIGNMENT

I, the undersigned, understand that I am financially responsible for the services rendered to patient, and authorize Community Medicine Foundation, Inc. to release any medical information required to receive payment for services rendered, which is billed to MEDICAID, MEDICARE, or Private Insurance(s). Failure to make timely payments may result in patient being discharged, and termination of medical services at the Center except in a life-threatening emergency. I understand that, if at anytime my account becomes more than 120 days past due my balance will be written off to bad debt, turned over to the Collection Agency, and I will be released as a patient from this practice.

Signed: **Date:** / /

NCFMC Staff:

Community Medicine Foundation, Inc.

PATIENT'S RESPONSIBILITY

We, here at North Central Family Medical Center (Community Medicine Foundation, Inc.) take pride in ensuring our patient's safety from the time that you enter our premises until you depart. To ensure that safety, it takes everyone involved to take responsibility for their actions. To have a better understanding of our center and the services that we offer, first and foremost, **WE ARE NOT A FREE CLINIC**. We are governed to do our best to serve you, the patient, regardless of your ability to pay. There are a list of rules that you are required to understand and comply with while a patient here at our center.

1. PERMISSION FOR TREATMENT: I hereby give permission to Community Medicine Foundation, Inc., DBA, North Central Family Medical Center to render what they determine to be the necessary medical treatment to my child(ren) or myself.
2. You, the patient, are responsible for the actions of your child(ren) and family member(s) that are here with you during your visit. We understand that your infant can become agitated (upset), but it is your responsibility to calm your child.
3. Due to limited space, there is a limit on the number of child(ren) and family member(s) allowed in the clinical and exam rooms. The maximum allowed is 1 person per patient (both child and/or family member).
4. No food is allowed in the center. If you must have something to eat, please do so before entering the building and dispose of your trash properly in the trash bins located outside of the building.
5. All cell phones must be turned off or kept on vibrator before entering the building. This is for everyone's safety due to some equipment that your phone may interrupt.
6. No shoes, No shirt, NO SERVICE. No heelys (shoes with skates) allowed on the premises.
7. No profanity. No running through the building.
8. A courtesy phone is located in the lobby if needed. All calls are limited to 2 minutes. LOCAL CALLS ONLY.
9. Payment for services (office visit, labs, shots, etc.) are due up front before you are allowed to be seen. The Center accepts as payment for medical services, Cash, Medicare, Medicaid and Credit Cards. Personal Checks are NOT accepted.

If you fail to follow these rules, there will be consequences for your actions or the actions of those that you bring with you to the center.

1. **First there will be a warning.**
2. **Second, if necessary, we will have to reschedule your appointment until you can find someone to baby-sit for you or until you can pay your bill (if it is outstanding for a period of time).**
3. **For the third and final time, we do have the right to dismiss you as a patient if you cannot comply with these rules.**

***By consenting to this form, you are agreeing to follow all rules and regulations of Community Medicine Foundation, Inc. DBA, North Central Family Medical Center.**

Community Medicine Foundation, Inc.

PATIENT'S RESPONSIBILITY

PATIENT NAME: _____ ACCT NO# _____

(Patient Signature) _____ (Date) _____

(NCFMC witness) _____

***By consenting to this form, you are agreeing to follow all rules and regulations of Community Medicine Foundation, Inc. DBA, North Central Family Medical Center.**

Date_____ Sliding Fee Expiration Date_____

Sliding Fee Code (circle one) A B C D SELFPAY

NORTH CENTRAL FAMILY MEDICAL CENTER

APPLICATION FOR SLIDING FEE

HOUSEHOLD MEMBERS

Name	Sex	Date of Birth	Relationship	Social Security Number	Identification Card
TOTAL IN HOUSEHOULD					

INCOME OF HOUSEHOLD

	SELF (A)	SPOUSE (B)	OTHER(S) (C)
1. IRS TAX FORM			
2. GROSS WAGES MONTHLY			
3. PUBLIC ASSISTANCE AFDC			
4. SOCIAL SECURITY BENEFITS			
5. UNEMPLOYMENT			
6. PENSION			
7. WORKERS COMPENSATION			
8. SSI / DISABILITY INSURANCE			
9. VETERANS BENEFITS			
10. RAILROAD RETIREMENT			
11. CHILD SUPPORT			
12. ALIMONY			
13. OTHER (SPECIFY)			
TOTAL HOUSEHOLD INCOME (Add Column A + B + C)			

I, THE UNDERSIGNED, CERTIFY THAT THE INCOME AND OTHER REGISTRATION INFORMATION GIVEN BY ME TO NCFMC FOR THE PURPOSE OF RECEIVING MEDICAL CARE FROM THE AUTHORIZED PROFESSIONAL STAFF OF NCFMC IS CORRECT AND ACCURATE.

SIGNED_____ **NCFMC STAFF_____**

(If minor, Legal Guardian)

Community Medicine Foundation, Inc. DBA
North Central Family Medical Center

Patient Authorization for Use and Disclosure of Protected Health Information

By signing, I authorize *Community Medicine Foundation, Inc. DBA North Central Family Medical Center* to use and/or disclose certain protected health information (PHI) about me to the following person(s).

_____ _____

_____ _____

This authorization permits *Community Medicine Foundation, Inc. DBA North Central Family Medical Center* to use and/or disclose the following individually identifiable health information about me (lab results, prescription medication information, details of office visit)

Patient information will be used or disclosed at the request of the individual.

This authorization will expire in one year.

I do not have to sign this authorization in order to receive treatment from *Community Medicine Foundation, Inc. DBA North Central Family Medical Center*. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the privacy officer at:

Community Medicine Foundation, Inc. DBA
North Central Family Medical Center
1131 Saluda Ave.
PO Box 28
Rock Hill, SC 29730

Signed by: _____ _____
Signature of Patient or Legal Guardian Relationship to Patient

_____ _____
Print Patient's Name Date

_____
Print Name of Patient or Legal Guardian, if applicable

Patient/guardian must be provided with a signed copy of this authorization form

_____
Staff signature/date

Approved 3/22/11

HIPAA NOTICE OF PRIVACY PRACTICES

Community Medicine Foundation

Effective Date: September 23, 2013

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE REVIEW IT CAREFULLY

If you have any questions about this notice, please contact ***Gina B. Howard***, Healthcare and HIPAA Compliance Officer at (803) 325-7744.

Who will follow this practice?

- North Central Family Medical Center Main
- North Central Family Medical Center Chester.
- North Central Pediatric & Adolescent Center.
- North Central Family Medical Center, Workman St.

This notice describes our privacy practices. We are affiliated with:

- North Central Family Medical Center Main
- North Central Family Medical Center, Chester.
- North Central Pediatric & Adolescent Center.
- North Central Family Medical Center, Workman St.

All these entities, sites, and locations follow the terms of this notice. In addition, these entities, sites, and locations may share health information with each other for treatment, payment, or health care operations purposes described in this notice.

OUR RESPONSIBILITY REGARDING HEALTH INFORMATION:

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

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YOUR RIGHTS: When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you. Get an electronic or paper copy of your medical record

Ask us how to do this.

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office (phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say "no" if it could affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.
- We will say "yes" unless a law requires us to share that information.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

YOUR CHOICES: For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation.
- Contact you for fundraising efforts.

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

OUR USES AND DISCLOSURES: How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Treat you

- We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

- We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Help with public health and safety issues

- We can share health information about you for certain situations such as:
- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

- We can use or share your information for health research.
- **Comply with the law**
- We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
- **Respond to lawsuits and legal actions**
- We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Bill for your services

- We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

- We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.

For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.htm

Respond to organ and tissue donation requests

- We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

- We can use or share health information about you:
- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

CHANGES TO THE TERMS OF THIS NOTICE: We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Acknowledgement of Receipt of this Notice

We will request that you sign a separate form or notice acknowledging you have received a copy of this notice. If you choose, or are not able to sign, a staff member will sign their name and date. This acknowledgement will be filed with your records.

☐ North Central Family Medical Center Main

☐ North Central Pediatric & Adolescent Center

☐ North Central Family Medical Center – Chester

☐ North Central Family Medical Center – Workman

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that on this date, I received a copy of the HIPAA Notice of Privacy Practices as published by Community Medicine Foundation, Inc.

_____ _____

Name (Printed) Medical Record Number

_____ _____

Signature Date

_____ _____

Signature of Witness Date

Scan into medical record

The Benefits of Being a Patient

Of

Community Medicine Pharmacy

- ✓ **Low Everyday Prices**
- ✓ **Select $3.99 Generics**
- ✓ **Helpful and Courteous Staff**
- ✓ **Personal Attention**
- ✓ **Accepts most RX plans**

Community Medicine Pharmacy

Located in

North Central Family Medical Center

Now are open on Saturdays from

9:30 am until 1:30 pm

(Rock Hill location ONLY)

COME SEE US TODAY

Operation Hours

Mon-Fri 8:30am until 5:30pm Sat 9:30am until 1:30pm

Closed for lunch Mon-Fri 12:30am until 1:30pm

(803)412-3352

SELECT GENERICS $3.99