ENROLLMENT FORM

Registration Number:_____________
Date:___________________________

CHECK ONE: ☐ HEAD OF HOUSE HOLD ☐ DEPENDENTS ☐ IDS ☐ VETERAN

MISS/MRS/Mr.(circle one)

____
Last First M.I

ADDRESS: ____________________________________TELEPHONE:________________________
Number Street Apt. No. Area Code Number

____
City State Zip Code

SEX: __M___F DATE OF BIRTH: ____/____/____ AGE:___ RACE:________ EMAIL ADDRESS_________________
Month Day Year

PLACE OF EMPLOYMENT: ____

ADDRESS: ____
No. Street City State Zip Code

OCCUPATION: ________________________________STATUS:______________ SSN:_______-_______-______

SPOUSE EMPLOYER: ____

ADDRESS: ____
No. Street City State Zip Code

OCCUPATION: ___________________________________STATUS:______________ __SSN: _____-____-_______

How did you learn about St. James-Santee Family Health Center, Inc. ☐ Family/Friend ☐ Agency Referral ☐ Employee ☐ Flyer ☐ Sign on Highway ☐ Newspaper/TV

INSURANCE INFORMATION:

MEDICARE:
Insured's Name__________________
Policy No.______________________

MEDICAID:
Insured's Name__________________
Policy No.______________________

PRIVATE INSURANCE:
Insured's Name__________________
Policy/Group____________________

ADDRESS: ___________________________
____

INSURED PERSON______________________

PAYMENT CODE: _______________________

ID No.	Last Name	First	Relation To Head
01			Head
10			Spouse
11			
12			
13			
14			
15			
16			
17			

GROSS FAMILY INCOME: $___________________

Verification Source:
☐ Check Stub ☐ Not Available
☐ Income Tax Statement ☐ Other (Specify)__________

EMERGENCY CONTACT:
NAME: ______________________________
TELEPHONE NO. ( ) ____________________

I, the undersigned, certify that the income and other registration information given by me to St. James Health and Wellness, for the purpose of receiving medical care from the authorized professional staff of St. James Health and Wellness, is accurate. I further understand that I am financially responsible for the services rendered to me and authorize SJHW to release any medical information required to receiver payment for services rendered to me which is billed to Medicare, Medicaid, or private insurance. Failure to make timely payments may result in my being dropped as a registrant and may no longer receive services at the center, except in a life threatening emergency. Thus, I hereby agree to abide by the rules outlined in this consent statement.

Signature_____________________________________ Interviewer's Signature______________
(if minor, Legal Guardian's Signature

Purpose of Interview_____________________________________Date__________________

Revised 3/2023 SJHW

Authorization for Telehealth Services

________ By initialing here, I give my consent to receive medical treatment from St. James Health & Wellness via telehealth modalities (e.g. tools which provide for remote audio and/or visual interaction between the patient and the healthcare provider) and/or remote patient monitoring (RPM) tools (collectively, "Telehealth"). The Telehealth service will be provided in a confidential manner and information will not be released without proper consent. I authorize physicians, nurse practitioners, physician assistants or designated health professionals to provide necessary and/or advisable treatment via Telehealth. I also understand that other individuals may be present to operate the video equipment and they will take the reasonable steps to maintain confidentiality of the information obtained. I understand that I have the right to ask my healthcare provider to discontinue the Telehealth encounter at any time.

I understand there are potential risks associated with this technology including that the video connection may stop working during the encounter, the video picture or information transmitted may not be clear enough to be useful for the encounter, and I may be asked to go to the location of the consulting healthcare provider if it is determined that the information obtained via Telehealth was not sufficient to make a diagnosis.

______________________________	______________________________
Patient Name	Patient Date of Birth
______________________________	______________________________
Patient (Parent/Guardian if minor) Signature	Date
______________________________	
Witness	

Sliding Fee Application & Self Declaration Form

Patient Name ________________________________ Account Number _______________________

Patient Address ____

City _____________________ State _______ Zip Code ___________ Telephone# ______________

Employer____________________________________ Employer Number ______________________

Current Family Size _____________________ Email Address _______________________________

List of Family Members: <u>Name(s)</u> <u>Birth Date(s)</u>

_________________________ ___________________

_________________________ ___________________

_________________________ ___________________

Current Gross Household Income: $__________ per (week, bi-weekly, month or year)

Attach proof of income (i.e. income tax return, check stub, unemployment statement etc.) and family members (i.e. income tax return, birth certificate, social security card).

______This certifies that <u>I wish</u> to apply for sliding fee discounted services at St. James Health and Wellness.

______This certifies that I <u>do not wish</u> to apply for sliding fee discounted services at St James Health and Wellness.

I declare that the income and family size indicated above is correct or that I am currently not working or receiving any type of benefits that could pay for services received at St. James Health and Wellness. I further declare that no other family member is receiving income that could pay for services. I understand that when I (or any family members listed above) begin receiving any type of benefits or any other changes in the household occur, I must report it to your agency immediately.

Proof of income or no income is required to participate in our sliding scale discounts. If no proof is provided, this application and Self-Declaration will <u>expire in 60 days</u>. Until proof of income is provided, you will be required to pay the full amount for services rendered in the future.

_____________________________________ ___________________

Signature of Applicant Date

_____________________________________ ___________________

Witness/Interviewer's Signature Date

Approved __________ Disapproved ________ Reason _____________________________________

Patient Name___________________________________ **Medical Record No:** ___________
Patient Address_________________________________ **Date of Birth:** _______________
City ____________**State**_______ **Zip Code**___________ **SSN:** ________-_________-_____

Authorization for Release of Information for Purposes
Requested by Physician's Office from another Covered Entity

I, __________________________________, hereby authorize __________________________ to disclose the following protected health information to St. James Health and Wellness: (Specifically describe the information to be disclosed, including, but not limited to meaningful descriptors such as date of service, type of service provided, level of detail to be released, origin of information, etc.).

____
____
____

This protected health information is being used or disclosed to carry out treatment, payment and/or health care operations of St. James Health and Wellness in the following manner: (Describe how protected health information will be used to carry out treatment, payment and/or health care operations purposes.)

____
____
____

This authorization shall be in force and effect until ______________________at which time this authorization
Month Day Year
to use or disclose this protected health information expires.

I understand that I have the right to revoke this authorization, in writing, at anytime by sending such written notification to the PRIVACY OFFICERS at St. James Health and Wellness. I understand that a revocation is not effective to the extent that St. James Health and Wellness has relied on the use or disclosure of the protected health information. I understand that my protected health information concerning sexually transmitted diseases and I authorize the release of this information for the purposes stated above. I understand that information used or disclosed pursuant to this authorization may be subject to disclosure by the recipient and may no longer be protected by federal or state law. _____________ (Patient's Initials)

St. James Health and Wellness will not condition my treatment, payment, enrollment (if applicable) in a health plan or eligibility for benefits on whether I provide authorization for the requested use or disclosure.

I understand that I have the right to refuse to sign this authorization.

_______________________________________ _______________________________________
Signature of Patient or Personal Representative Printed Name of Patient or Personal Representative

___________________ _______________________________________
Date Relationship to Patient (or other authorization)

Consent for Purpose of Treatment, Payment and Healthcare Operations

I consent the use of disclosure of my protected health information by St. James Health and Wellness for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care operations of St. James Health and Wellness. I understand that diagnosis or treatment by St. James Health and Wellness Physicians may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. St. James Health and Wellness is not required to agree to the restrictions that I may request. However, St. James Health and Wellness agree to a restriction that I may request, the restrictions is binding on St. James Health and Wellness and its physicians.

I have the right to revoke this consent, writing, at any time, except to the extent that St. James Health and Wellness has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health provider, a health plan, my employer or a health care clearinghouse. This protected health information related to my past, present, or future physical or mental health or condition and identifies me, or there is a reasonable basis to believer the information may identify me. *I understand that my protected health information may include information concerning sexually transmitted diseases and I consent to release of the information for the purpose as stated above*________ (Patient Initials).

I understand I have the right to review St. James Health and Wellness Notice of Privacy Practices prior to signing this document. The St. James Health and Wellness. Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the St. James Health and Wellness. The Notice of Privacy Practices for St. James Health and Wellness is also provided in the office of the Privacy Officer. The Notice of Privacy Practices also describes my rights and the St. James Health and Wellness duties with respect to my protected health information.

St. James Health and Wellness reserves the right to change the privacy practices that are described in the Notice of Privacy Practices, (may obtain a revised notice of the privacy practice by recessing the St. James Health and Wellness website, calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my appointment.

______________________________	______________________________
Signature of Patient or Personal Representative	Name of Patient Or Personal Representative (please print)
______________________________	______________________________
Date	Relationship Of Patient For Other Authority To Serve

Georgetown Pediatric	McClellanville	Sampit/N.Santee	Choppee	N. Fraser St	Andrews
57 Jessamine Ave.	1189 Tibwin Rd	2482 Powell Rd	8189 Choppee Rd	422 N. Fraser st	675 North Morgan Ave
Georgetown, SC 29440	McClellanville, SC 29458	Georgetown, SC 29440	Georgetown, SC 29440	Georgetown, SC 29440	Andrews, SC 29510
Tel. 843-546-8686	Tel: 843 887 3274	Tel: 843 527 7533	Tel: 843 5458723	Tel: 843 436 1333	Tel: 843 264 2680
Fax 843-546-1353	Fax: 843 887 3929	Fax: 843 527 7940	Fax: 843 5458346	Fax: 843 436 1335	Fax: 843 264- 2690
Mailing Address	Mailing Address	Mailing Address	Mailing Address	Mailing Address	Mailing Address
PO Box 608	PO Box 608	PO Box 608	PO Box 608	PO Box 608	PO Box 608
McClellanville, SC 29458	McClellanville, SC 29458	McClellanville, SC 29458	McClellanville, SC 29458	McClellanville, SC 29458	McClellanville, SC 29458

Personal Health Information (PHI) Disclosure to Family Members

You may authorize us to contact one or more family members and/or friends regarding your medical care. This is to acknowledge that you authorize St James Health and Wellness staff to (check all that apply.) I further authorize the disclosure of my PHI to the following individuals or family members:

Name________________________________ ☐ Results (lab test, x-ray) ☐ Appointments Remainders>

Relationship to Patient ________________ ☐ Other ☐ Financial

Contact Information Phone __________________ ☐ Voice mail Email ___________________________

Name________________________________ ☐ Results (lab test, x-ray) ☐ Appointments Remainders>

Relationship to Patient ________________ ☐ Other ☐ Financial

Contact Information Phone __________________ ☐ Voice mail Email ___________________________

Name________________________________ ☐ Results (lab test, x-ray) ☐ Appointments Remainders>

Relationship to Patient ________________ ☐ Other ☐ Financial

Contact Information Phone __________________ ☐ Voice mail Email ___________________________

Name________________________________ ☐ Results (lab test, x-ray) ☐ Appointments Remainders>

Relationship to Patient ________________ ☐ Other ☐ Financial

Contact Information Phone __________________ ☐ Voice mail Email ___________________________

☐ I do not authorize my PHI to be released to any person other than myself

Patient Signature______________________________________ Date ____________________

Witness Signature______________________________________ Date ____________________

Medical Release Form

Name: ________________________________ Date:__________________

If you are a new patient to our practice, we would appreciate a list of all doctors you have seen over the past three years so that we may obtain records from them. If you are a woman, please include the office where you have received your gynecological care. Please fill out as much information as you can. Thank you for your assistance with this.

Doctor's (or office Name) ____
Office address____
Office telephone number____
Approximate dates seen in our office____

Doctor's (or office Name) ____
Office address____
Office telephone number____
Approximate dates seen in our office____

Doctor's (or office Name) ____
Office address____
Office telephone number____
Approximate dates seen in our office____

Doctor's (or office Name) ____
Office address____
Office telephone number____
Approximate dates seen in our office____

Doctor's (or office Name) ____
Doctor's (or office Name) ____
Office address____
Office telephone number____
Approximate dates seen in our office____

Please fill out the top of the following form and sign and date the bottom so that we can send it to your past health care providers for your past records.

______________________________ ______________________________
Signature of Patient or Representative Printed Name of Patient or Representative

____
Date

SJHW-2023

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I, ___________________________received a copy of the St. James Health and Wellness Privacy Notice.
(Patient)

Patient Signature:_______________________________ Date: _____________________________

“Your health matters.”

SJHW-9/14/2021

Notice of Privacy Practices

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. If you have any questions about this Notice please contact our Privacy Officer at: (843) 887-3274.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations 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 or condition and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices by calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information Based Upon Your Written Consent.

You will be asked by your physician to sign a consent form. Once you have consented to use and disclosure of your protected health information for treatment, payment and health care operations by signing the consent form, your physician will use or disclose your protected health information as described in this Section 1. 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. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of the physician's practice.

Following are examples of the types of uses and disclosures of your protected health care information that the physician's office is permitted to make once you have signed our consent form. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office once you have provided consent.

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 that has already obtained your permission to have access to your protected health information. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you when we have the necessary permission from you to disclose your protected health information. 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.

In addition, we may disclose your protected health information from time-to time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

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 activities, employee review activities, training of medical students, licensing, marketing and fundraising activities, and conducting or arranging for other business activities.

For example, we may disclose your protected health information to medical school students who 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.

We will share your protected health information with third party "business associates" that perform various activities (e.g., billing, transcription services) for the practice.

Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health related benefits and services that may be of interest to you. We may also use and disclose your protected health information for other marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer. We may also send you information about products or services that we believe may be beneficial to you. You may contact our Privacy Officer to request that these materials not be sent to you.

We may use or disclose your demographic information and the dates that you received treatment from your physician, as necessary, in order to contact you for fundraising activities supported by our office. If you do not want to receive these materials, please contact our Privacy Officer and request that these fundraising materials not be sent to you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as; making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. 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.

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this 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.

Other Permitted and Required Uses and Disclosures That May Be Made With Your Consent, Authorization or Opportunity to Object

We may use and disclose your protected health information in the following instances.

You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose 'such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information 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. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Emergencies: We may use or disclose your protected health information in an emergency treatment situation. If this happens, your physician shall try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If your physician or another physician in the practice is required by law to treat you and the physician has attempted to obtain your consent but is unable to obtain your consent, he or she may still use or disclose your protected health information to treat you.

Communication Barriers: We may use and disclose your protected health information if your physician or another physician in the practice attempts to obtain consent from you but is unable to do so due to substantial communication barriers and the physician determines, using professional judgment, that you intend to consent to use or disclosure under the circumstances.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Consent, Authorization or Opportunity to Object

We may use or disclose your protected health information in the following situations without your consent or authorization. These situations include:

Required By Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified,

if required by law, of any such uses or disclosures.

Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made in accordance with state law for the purpose of controlling disease, injury or disability. We may also disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

Communicable Diseases: We may disclose your protected health information, according to state law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information under law. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include: (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of the practice, and (6) medical emergency (not on the Practice's premises) and it is likely that a crime has occurred.

Coroners, Funeral Directors, and Organ Donation: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

Research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

Workers' Compensation: Your protected health information may be disclosed by us as authorized to comply with workers' compensation Jaws and other similar legally• established programs.

Inmates: We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 et. esq.

2. Your Rights

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. A "designated record set" contains medical and billing records and any other records that your physician and the practice uses for making decisions about you.

Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Officer if you have questions about access to your medical record.

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 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 a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If your physician does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician. You may request a restriction by contacting your physician at the Center.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Officer.

You may have the right to have your physician amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. 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. Please contact our Privacy Officer to determine if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any of your protected health information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you, for a facility directory, to family members or friends involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. You may request a shorter timeframe. The right to receive this information is subject to certain exceptions, restrictions and limitations.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

3. 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 privacy contact of your complaint. We will not retaliate against you for filing a complaint. You may contact our Privacy Officer at (**843)-887- 3274 or e-mail: gbrown@stjamessanteefhc.com** for further information about the complaint process.

This notice was published and becomes effective on April 14, 2003.

No Surprises: What's a good faith estimate?

If you don't have health insurance or you plan to pay for health care bills yourself, generally, health care providers and facilities must give you an estimate of expected charges when you schedule an appointment for a health care item or service, or if you ask for an estimate. This is called a "good faith estimate."

A good faith estimate isn't a bill

The good faith estimate shows the list of expected charges for items or services from your provider or facility. Because the good faith estimate is based on information known at the time your provider or facility creates the estimate, it won't include any unknown or unexpected costs that may be added during your treatment. Generally, the good faith estimate must include expected charges for:

- The primary item or service
- Any other items or services you're reasonably expected to get as part of the primary item or service for that period of care.

The estimate might not include every item or service you get from another provider or facility, even if some items or services may seem connected to the same service. For example, if you're getting surgery, the good faith estimate could include the cost of the surgery, anesthesia, any lab services, or tests.

In some cases, items or services related to the surgery **that are scheduled separately**, like certain pre-surgery appointments or physical therapy in the weeks after the surgery, might not be included in the good faith estimate. You'll get a separate good faith estimate when you schedule those items or services with the provider or facility, or if you ask for it.

Your right to a good faith estimate

Providers and facilities must give you the good faith estimate:

- After you schedule a health care item or service. If you schedule an item or service at least 3 business days before the date you'll get the item or service, the provider must give you a good faith estimate no later than 1 business day after scheduling. If you schedule the item or service OR ask for cost information about it at least 10 business days before the date you get the item or service, the provider or facility must give you a good faith estimate no later than 3 business days after you schedule or ask for the estimate.
- That includes a list of each item or service (with the provider or facility), and specific details, like the health care service code.
- In a way that's accessible to you, like in large print, Braille, audio files, or other forms of communication.

Providers and facilities must also explain the good faith estimate to you over the phone or in person if you ask, then follow up with a written (paper or electronic) estimate, per your preferred form of communication.

Keep the estimate in a safe place so you can compare it to any bills you get later. After you get a bill for the items or services, if the billed amount is $400 or more above the good faith estimate, you may be eligible to dispute the bill.

For more information, review an example of what a good faith estimate may include (PDF) and examples of good faith estimates that do and don't qualify for the dispute process (PDF).

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No Surprises:
Understand your rights against surprise medical bills

The No Surprises Act protects people covered under group and individual health plans from receiving surprise medical bills when they receive most emergency services, non-emergency services from out-of-network providers at in-network facilities, and services from out-of-network air ambulance service providers. It also establishes an independent dispute resolution process for payment disputes between plans and providers, and provides new dispute resolution opportunities for uninsured and self-pay individuals when they receive a medical bill that is substantially greater than the good faith estimate they get from the provider.

Starting in 2022, there are new protections that prevent surprise medical bills. If you have private health insurance, these new protections ban the most common types of surprise bills. If you're uninsured or you decide not to use your health insurance for a service, under these protections, you can often get a good faith estimate of the cost of your care up front, before your visit. If you disagree with your bill, you may be able to dispute the charges. Here's what you need to know about your new rights.

What are surprise medical bills?

- Before the No Surprises Act, if you had health insurance and received care from an out-of-network provider or an out-of-network facility, even unknowingly, your health plan may not have covered the entire out-of-network cost. This could have left you with higher costs than if you got care from an in-network provider or facility. In addition to any out-of-network cost sharing you might have owed, the out-of-network provider or facility could bill you for the difference between the billed charge and the amount your health plan paid, unless banned by state law. This is called "balance billing." An unexpected balance bill from an out-of-network provider is also called a surprise medical bill. People with Medicare and Medicaid already enjoy these protections and are not at risk for surprise billing.

What are the new protections if I have health insurance?

If you get health coverage through your employer, a Health Insurance Marketplace®, [1] or an individual health insurance plan you purchase directly from an insurance company, these new rules will:

- Ban surprise bills for most emergency services, even if you get them out-of-network and without approval beforehand (prior authorization).
- Ban out-of-network cost-sharing (like out-of-network coinsurance or copayments) for most emergency and some non-emergency services. You can't be charged more than in-network cost-sharing for these services.
- Ban out-of-network charges and balance bills for certain additional services (like anesthesiology or radiology) furnished by out-of-network providers as part of a patient's visit to an in-network facility.
- Require that health care providers and facilities give you an easy-to-understand notice explaining the applicable billing protections, who to contact if you have concerns that a provider or facility has violated the protections, and that patient consent is required to waive billing protections (i.e., you must receive notice of and consent to being balance billed by an out-of-network provider).

[1] Health Insurance Marketplace® is a registered service mark of the U.S. Department of Health & Human Services.

What if I don't have health insurance or choose to pay for care on my own without using my health insurance (also known as "self-paying")?

If you don't have insurance or you self-pay for care, in most cases, these new rules make sure you can get a good faith estimate of how much your care will cost before you receive it.

What if I'm charged more than my good faith estimate?

For services provided in 2022, you can dispute a medical bill if your final charges are at least $400 higher than your good faith estimate and you file your dispute claim within 120 days of the date on your bill.

What if I do not have insurance from an employer, a Marketplace, or an individual plan? Do these new protections apply to me?

Some health insurance coverage programs already have protections against surprise medical bills. If you have coverage through Medicare, Medicaid, or TRICARE, or receive care through the Indian Health Services or Veterans Health Administration, you don't need to worry because you're already protected against surprise medical bills from providers and facilities that participate in these programs.

What if my state has a surprise billing law?

The No Surprises Act supplements state surprise billing laws; it does not supplant them. The No Surprises Act instead creates a "floor" for consumer protections against surprise bills from out-of-network providers and related higher cost-sharing responsibility for patients. So as a general matter, as long as a state's surprise billing law provides at least the same level of consumer protections against surprise bills and higher cost-sharing as does the No Surprises Act and its implementing regulations, the state law generally will apply. For example, if your state operates its own patient-provider dispute resolution process that determines appropriate payment rates for self-pay consumers and Health and Human Services (HHS) has determined that the state's process meets or exceeds the minimum requirements under the federal patient-provider dispute resolution process, then HHS will defer to the state process and would not accept such disputes into the Federal process.

As another example, if your state has an All-Payer Model Agreement or another state law that determines payment amounts to out-of-network providers and facilities for a service, the All-Payer Model Agreement or other state law will generally determine your cost-sharing amount and the out-of-network payment rate.

Where can I learn more?

Still have questions? Visit **CMS.gov/nosurprises**, or call the Help Desk at 1-800-985-3059 for more information. TTY users can call 1-800-985-3059.

No Surprises:
How do I read my medical bill?

Getting a medical bill from a health care provider or facility can be confusing. Here are some of the most important items you're likely to see on a medical bill:

- **Name and address.** Make sure your name (or your dependent's name) and other personal information is correct before reviewing the rest of the bill.
- **Statement date.** This is the date your provider's or facility's billing office printed the bill.
- **Name and address of the provider(s) or facility.** Make sure you understand which provider or facility is billing you. If you don't see your provider's or facility's name or medical practice on the bill or you see a different name, call the number on your bill and ask them about the name.
- **Account number.** This number is assigned by the provider or facility and is unique to you. Use it to pay your bill so you get credit for your payments. You might also need to give this number to your provider or facility if you have billing questions.
- **Date(s) of the service.** Make sure you got services on the date(s) listed.
- **Description of services or supplies.** Make sure the services or supplies listed are the ones you received on those dates. Sometimes the descriptions are very general, have abbreviations, or include complex medical terms or billing codes. If you don't understand the listed service or supply, contact your provider or facility.
- **The costs of services or supplies.** When reviewing the charges on your bill, you'll see several different amounts that often include:
    - **Total charges:** The full price for the service(s) and/or item(s).
    - **Allowed amount:** The maximum amount a plan will pay for a covered health care service. The allowed amount may also be called "eligible expense," "payment allowance," or "negotiated rate." If your provider or facility is out of network and charges more than the plan's allowed amount, you may have to pay the difference. This is called "balance billing."
    - **Adjustments:** An amount your providers or facility subtract from the total charges because they have agreed to discount or charge a lower amount for that service.
    - **Insurance payment:** The amount your insurance paid or is expected to pay (if you have insurance), up to the allowed amount, after you pay your share of the cost.
    - **Patient payment:** Any amount you may have already paid to your provider or facility when you got the service or supply, like a copayment.
    - **Balance due/Patient responsibility:** The amount you still owe the provider or facility based on that bill, like a deductible or coinsurance.
- **How to pay the bill.** This is usually found at the very top or bottom of the bill, sometimes on a detachable payment slip. Look here to find the different ways to pay your bill (like mail or online) and who to pay.

Is a medical bill the same as an Explanation of Benefits?

No, a bill isn't the same as an Explanation of Benefits. If you have health insurance, an Explanation of Benefits is a notice you get from your health plan that shows the costs of your care. It includes the services you got and the date you got them, the amount your health plan agrees to pay, and the amount you owe, if anything.

You should get an Explanation of Benefits from your health plan **before** you get a medical bill from your provider's office (except for a copayment or coinsurance, which the provider or facility might ask for at the time you get your health care service). If you don't get an Explanation of Benefits, contact your health plan to make sure your provider's office or facility has sent them a claim for your service or supply.

What should I do with the Explanation of Benefits?

Review your Explanation of Benefits and check it for mistakes. When you get a bill from your provider or facility, compare it with the Explanation of Benefits to make sure you were billed for the correct services and supplies. Also, compare the amount on your medical bill to the amount the Explanation of Benefits says you owe to make sure the amount is correct.

Remember, you could get separate Explanation of Benefits for each type of service or supply you got, if you got services from more than one provider or facility, or if you got treatment on more than one day. Make sure you save these notices for your records. Only make payments after you get a bill from your provider or facility, and check to make sure that the services and amounts you owe are the same as those shown in your Explanation of Benefits.

What if I don't have health insurance?

If you don't have health insurance, or you have health insurance but don't plan to submit your claim to your health plan, you'll usually need to pay the full amount shown on the bill. Your provider or facility must give you a "good faith estimate" of expected charges before you get an item or service if you ask for one, or after you've scheduled an item or service at least 3 business days in advance. Be sure to keep the good faith estimate in a safe place so you can compare it to any bills you get later.

If you find that the amount you're billed for an item or service is $400 or more above the amount of the good faith estimate, you may be able to dispute the bill. Visit CMS.gov/nosurprises/consumers/medical-bill-disagreements-if-you-are-uninsured to learn more about billing disagreements.

Who should I contact with questions about my bill?

If you have questions about your medical bill, or you think there's an error on your bill or Explanation of Benefits, contact your provider or facility.

To learn more about the Explanation of Benefits, visit CMS.gov/files/document/11819-sample-explanation-benefits-508.pdf.

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