Millennium Internal Medicine

New Patient Packet

What to bring to appointment:

- Insurance card
- ID
- All current medication(in the bottle)
- Completed new patient packet

Appointment Time: _____
Appointment Date: _____
Provider: _____

Please arrive 30 minutes prior to appointment time to allow time to update records.

Millennium
Internal Medicine

BON SECOURS
ST. FRANCIS HEALTH SYSTEM

2 Innovation Drive Suite 300A, Greenville, SC 29607
Phone 864-365-0123, Fax 1-877-249-9524

Patient Information

Full Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Social Security # ___-___-___ Date of Birth: ___/___/___

E-mail: _____ Race _____ Sex: F M

Ethnicity: _____ Language: _____

Home Phone: (___) ___-___ Cell: (___) ___-___

Work: (___) ___-___

Do you have any cultural/religious considerations that we need to be aware of?

_____

_____

Are you hard of hearing? Yes or No Do you have vision problems? Yes or No

Other communication issues? _____

Living Will? Yes or No POA: _____

Emergency Contact

Name _____ Relationship _____ Phone (___) ___-___

Disease Prevention and Health Maintenance					
	Month/Year		**Month/Year**		**Month/Year**
Flu Vaccine		Mammogram		Eye Exam	
Pneumonia Vaccine		Pap Smear		Heart Catheterizations	
Tetanus Vaccine		Colonoscopy		Endoscopy (EGD)	
EKG		Prostate Exam		Bone Density	

Medical History: (Please place a check below for any past or ongoing medical problems).

_____ **NONE OF BELOW**

_____Allergies
_____AIDS/HIV
_____Amputation
_____Anemia
_____Anxiety
_____Arthritis
_____Asthma/COPD
_____Autoimmune Disease
_____Back Problems
_____Bleeding Disorders
_____Broken Bones
_____Cancer
_____Cholesterol Problems
_____Circulation Problems
_____Colon Polyps
_____Crohns/Ulcerative Colitis
_____Depression
_____Diabetes
_____Diverticulitis
_____Emphysema/COPD
_____Epilepsy/Seizures
_____Fibromyalgia
_____Ear Problems
_____GERD (Reflux)
_____GI Diseases
_____Hiatal Hernia
_____Headaches
_____Hearing Issues
_____Hernia
_____High Blood Pressure
_____Irritable Bowel/Spastic Colon
_____Infectious Disease
_____Kidney Problems
_____Muscular Disease
_____Osteoporosis
_____Pancreatitis
_____Phlebitis/Blood Clot
_____Psychiatric Problem
_____Paralysis
_____Pneumonia
_____Prostate Problems
_____Skin Rash/Eczema
_____Sleep Disorder
_____Stomach Ulcer
_____Stroke/TIA
_____Substance Abuse
_____Thyroid Problems
_____Tuberculosis
_____Urinary Tract Infections
_____STD
_____Visual Eye Problems
_____Other:_____
_____
_____

Past Surgical Procedures / Hospitalizations / Serious Injuries or Fractures

Operations/Hospitalizations/Injury	Month/Year	Operations/Hospitalizations/Injury	Month/Year

Family Medical History

Relative	Living or Deceased	Current age or age at death	Cause of Death	Health Issues (include mental health/Substance Abuse History)
Mother				
Father				
Sibling				

Social History

Marital Status:	How many children:	Work Status: (Circle one): Employed/Unemployed / Retired / Disabled
What type of exercise do you perform, duration & frequency?		
Do you drink alcohol?	How much do you drink per week?	Do you smoke?
Are you a former smoker?	When did you quit smoking?	How much do you smoke per day?
Do you wear your seatbelt?	Do you have a fire extinguisher in your home?	Do you have a smoke detector in your home?

Other Physicians and Specialists

List below your other physicians

Doctor	**Specialty**
Example: Dr. Smith	*Cardiologist*

Please list all drug/food allergies & reaction: _____

_____

Desired Pharmacy for ***all*** medication needs:

Name: _____

Location: _____

Phone & Fax: _____

Medications, Vitamins, and Herbal Supplements		
Medication	**Strength**	**Number of pills taken & frequency**
Example: Tylenol	*500 mg*	*1 – taken twice daily*

Authorization to Use and Disclose Protected Health Information

Use and Disclosure of Your Protected Health Information
Your protected health information will be used by or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice. There is potential for re-disclosure. The person or organization to which health information is sent may repeatedly disclose health information that is identified by this authorization. The privacy of this information may not be protected under the federal privacy regulations.

Notice of Privacy Practices
We are required to provide you with a notice that describes how information about you may be used and disclosed. Additionally, we must provide you information on how you may get access to this information. These policies and practices are defined in the "Notice of Privacy Policies and Practices" letter provided to you. **PLEASE REVIEW IT CAREFULLY.**

Requesting a Restriction on the Use or Disclosure of Your Information
You may request a restriction on the use or disclosure of your protected health information. Millennium Internal Medicine may or may not agree to restrict the use or disclosure of your protected health information. If Millennium Internal Medicine agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected health information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent
You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected. Contact Ashley Garrett (864) 365-0123 to terminate this authorization.

Reservation of Right to Change Privacy Practices
Millennium Internal Medicine reserves the right to modify the privacy practices outlined in the notice. I understand that Millennium Internal Medicine will notify me of these changes via the method I have authorized or upon my next appointment.

Rights of the Individual
*You may inspect or copy the information used or disclosed under this authorization by contacting Ashley Garrett (864) 365-0123.

*You may refuse to sign this authorization. If you refuse to sign, Millennium Internal Medicine, will not deny you treatment.

1. Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis: **If you wish a spouse, step-parent, child, secretary, friend, etc. to have access to appointment times, health information, and/or billing information, please lists them here.**

_____ **may have access to: all info billing info only diagnosis/medical info only**
_____ **may have access to: all info billing info only diagnosis/medical info only**
_____ **may have access to: all info billing info only diagnosis/medical info only**
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_____ **may have access to: all info billing info only diagnosis/medical info only**

2. You're billing statements and/or correspondence from our office will be sent to the address provided by you on your patient information sheet. All clinical correspondence will be marked "CONFIDENTIAL" when mailed directly from our office.
3. The practice may use your information to remind you about upcoming appointments. Typically, appointment reminders are done by telephone and a brief, nonspecific message may be left on your answering machine or voicemail. The home number you provided on your patient information sheet will be used to contact you. We may also leave messages regarding treatment and/or other information pertinent to your healthcare and payment for your care provided at Millennium Internal Medicine.

If you do not wish to be contacted in this manner, how else may we contact you? _____

I have reviewed this consent form, received the notice entitled "Notice of Privacy Policies and Practices" and give my permission to Millennium Internal Medicine to use and disclose my health information in accordance with this consent and the notice provided.

Name of Patient (Print/Type) Signature of Patient OR Signature of Patient Representative Date

Relationship of Patient Representative to Patient

Millennium Internal Medicine Medication Policy

Pain Medications

Although it is our goal to provide the best and most comprehensive care possible, it is not our intention to manage chronic pain using narcotic pain medications. As such, patients requiring long term narcotic pain medications will be referred to a pain management center experienced in managing such conditions. Additionally, this office will not normally prescribe certain schedule II analgesic medications such as Oxycontin, Fentanyl, Morphine, Methadone, Hydrocodone, Dilaudid, etc. We may occasionally prescribe a short term schedule II or III analgesic medication for acute, self-limiting pain, at the discretion of the individual provider. For patient safety, this office requires patients to get their pain medications from one medical doctor only.

Controlled Stimulant Medications (ADD/ADHD Medications)

Stimulant medications for the treatment of ADD/ADHD may be prescribed for a patient with a documented diagnosis from a mental health professional. Routine follow-up visits will be required every 3 months. Prescriptions for this class of medications will be written for only 1 month at a time.

Benzodiazepines:

Benzodiazepine medications such as Xanax, Valium, Ativan, etc. will not be prescribed for long term use. Patients requiring treatment for anxiety beyond an acute episode will be referred to a mental health professional, and then you will be required to follow up every 3 months.

Prescription Refills:

Please be aware that lost prescriptions for schedule II and III medications WILL NOT be replaced.

Also be aware that it is our intention to provide the best possible care for every individual patient that we treat and the decision to prescribe these medications in any circumstance remains that of the prescribing physician.

Requests WILL NOT be filled early. You must follow the directions on the bottle, and not take medications more frequently than indicated. Additionally, it is the patient's responsibility to request refills in advance of running out of the prescription. Refills may take up to three (3) business days to complete. Refills WILL NOT be filled on an urgent basis. Do not call the "on-call" physician for refills of narcotic pain medications. **NO narcotic pain medication prescription can be called in per Federal Law.**

If you are prescribed a controlled substance, then you are required to bring unused medications to all appointments. Failure to comply with any of these policies may result in dismissal from the practice.

I HAVE READ AND UNDERSTAND THESE POLICIES.

Patient Signature: _____ Date: _____

Patient Name Printed: _____

Millennium Internal Medicine
2 Innovation Dr., Suite 300A
Greenville SC, 29607
Phone: (864) 365-0123
Fax: (877) 249-9524

DN-0829

Bon Secours

Authorization for Release of Protected Health Information

Patient's Full Name at the Time of Treatment: _____
Patient Address: _____ City: _____ State: _____ Zip: _____
Date of Birth: _____ Social Security Number: _____
Date(s) of Treatment: _____
Purpose of Release: _____

I authorize Bon Secours St. Francis Health System to release my health information to:
_____ Recipient's Address: _____
City: _____ State: _____ Zip: _____ Phone No. _____ Fax No. _____

- ☐ Mail Record
- ☐ I will pick up
- ☐ Save To File/CD
- ☐ FAX (to health provider or health plan only)
- ☐ Other: _____
- ☐ My Chart

I, the above patient, hereby authorize _____ to release a copy of my records to Bon Secours St. Francis Health System.

Information to be released: (please check all that apply)

- ☐ All records
- ☐ Inpatient medical records
- ☐ Outpatient medial records
- ☐ Billing records
- ☐ Records from physician: _____
- ☐ Records from Open Arms Hospice
- ☐ Records from St. Francis Hospital
- ☐ Records from St. Francis Eastside Hospital
- ☐ Pathology reports
- ☐ Laboratory report
- ☐ Radiology Film Type: _____
- ☐ Radiology reports
- ☐ Psychotherapy records
- ☐ Drug and/or alcohol use records
- ☐ Records from Upstate Surgery Center
- ☐ Other: _____

1) I understand that if my records contain documentation of **alcohol abuse, psychiatric condition, drug abuse, or communicable diseases**, this information will be released as part of my record.
2) I understand that if the person or entity receiving this information is not covered by federal privacy regulations, this information will no longer be protected and may be re-disclosed.
3) I understand that I may revoke this authorization at any time, but revocation will not apply to information that has already been released. *Note: Request must be in writing and forwarded to the medical information department.*
4) I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment.
5) I understand that there may be a charge for obtaining the requested information. Information on the charge can be obtained by contacting the medical information department.
6) I understand that this authorization will expire in 90 days unless an earlier date is specified here _____.

_____ _____ am / pm
Signature of Patient or Personal Representative Date/Time

_____
Relationship to Patient / Authority to Act for Patient

PROVIDER USE ONLY

Original to Medical Records (Date) _____ (Time) _____

Verification Completed By _____

A copy of this signed authorization must be given to the individual.

Notice of Privacy Practices

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

Our Pledge to You

We understand that your medical information is personal. We are committed to protecting you medical information. We create a record of the care and services you received to provide quality care and to comply with legal requirements. This notice applies to all the records of your care that we maintain, whether created by our staff, physician, or treatment notes from other providers of medical care. We are required by law to:

- Keep medical information about you private.
- Give you notice of our privacy practices with respect to medical information about you.
- Follow the terms of the notice that is currently in effect.

Changes to this Notice

We may change our policies at any time. Changes will apply to medical information we already hold, as well as new information after the change occurs. Before we make a significant change in our policies, we will change our notices and post new notices. You may receive a copy of the current notice anytime. You will be asked to acknowledge in writing your receipt of this notice.

How We May Use and Disclose Your Medical Information

- We may use and disclose medical information about you for **treatment** (such as sending medical information about you to another physician as part of a referral); **to obtain payment for treatment** (such as sending billing information to your insurance company or Medicare); and **to support our health care operations** (such as calling patient test results, treatment options etc.)
- We may use or disclose medical information about you **without** your prior authorization for several reasons. Subject to certain requirements, we may give out medical information about you without prior authorization for **public health purposes, abuse or neglect reporting, funeral arrangements, organ donation, Worker's Compensation purposes and emergencies.** We also disclose medical information when **required by law**, such as in response to law enforcement or in response to valid judicial or administrative orders. We may also disclose medical information about you to a **friend, family member or personal representative as designated by you.**

Rights Regarding Your Medical Information

- In most cases, **you have the right to look at or get a copy of medical information that we use** to make decisions about your care when you submit a written request. We are committed to acting in good faith in responding to your access request, and to the requirements of the HIPAA privacy rules and any other federal or State statues or regulations that may be stricter than HIPAA in granting access to personal health information. If you request copies **we may charge a fee for copying, mailing or other related supplies.** If we deny your request to review or obtain a copy, you may submit a written request for a review of that decision.
- If you believe that information in your record is incorrect or if important information is missing, **you have the right to request that we correct the records** by submitting a request in writing that provides your reason for requesting amendment. We could deny your request to amend a record if we did not create the information; if it is not part of the medical information that we maintain; or if we determine that the record is accurate. You may appeal, in writing, our decision not to amend a record.
- **You have the right to a list of those instances where we have disclosed medical information about you**, other than for treatment, payment, health care operations, or where you specifically authorized a disclosure. This request must be submitted to us in writing. The request must state the time period desired for the accounting which must be less than a six-year period and starting after April 14, 2003.

- **You have the right to request that medical information about you be communicated to you in a confidential manner**, such as sending mail to an address other than your home, by notifying us in writing of the specific way or location for us to use to communicate with you.

Other Uses of Medical Information

In any other situation not covered by this notice, we will ask for your written authorization before disclosing medical information about you. If you choose to authorize use or disclosure, you can later revoke that authorization by notifying us in writing of your decision. You may request, in writing, that we not disclose medical information about you for treatment, payment, or health care operations unless required by S.C. law. However, **YOU WILL BE RESPONSIBLE FOR YOUR BILL.**

- **You have a right to amend your personal medical information.** We will consider the request but WE ARE NOT LEGALLY REQUIRED TO ACCEPT IT. We will inform you of our decision on your request.

Complaints

If you are concerned that your privacy rights have been violated, or you disagree with a decision we made about access to your records, you may contact Ashley Garrett at (864) 365-0123.

You may also send a written complaint to or call:
(202) 619-0257
The U.S. Department of Health & Human Services Office of Civil Rights
200 Independence Ave
Washington, D.C. 20201

Under no circumstances will you be penalized or retaliated against for filing a complaint.

If you have any questions you may contact Ashley Garrett, Administrator:
Millennium Internal Medicine
2 Innovation Dr.
Suite 300A
Greenville, SC 29607
(864) 365-0135

Millennium
Internal Medicine

BON SECOURS
ST. FRANCIS HEALTH SYSTEM

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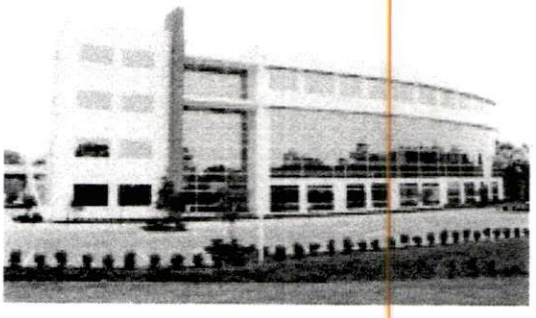

Millennium Internal Medicine is located at 2 Innovation Drive, Suite 300A, Greenville, SC, 29607. From I-85 take exit # 48A Laurens Road, heading South towards Mauldin. The Millennium building is located 1.5 miles South of this exit on the Left hand side of Laurens Road at the intersection of Innovation Drive. Then we are the 3rd floor suite 300A. For more interactive directions go online at **www.stfrancishealth.org/**. Go under the "patients & visitors" tab. Click on the "maps & directions" heading. Then click on the link "Browse all of our facilities on Google Maps" which will take you to interactive maps with St. Francis millennium listed towards the bottom.