Sandhills Family Practice, P.A.

Welcome to Our Office!

Doctor_____
Chart#_____

How will you be taking care of today's visit?
☐ Cash ☐ Check ☐ Bankcard ☐ Other

PATIENT INFORMATION

Patient Name
_____
Last First Middle

Mailing Address _____
_____
City State Zip Code

Home Phone# | Business Phone#

Cell Phone# | Social Security # | Birth Date

Marital Status: S M W D Separated | Driver's License#

Employer or School

Address _____
_____
City State Zip Code

Whom May We Contact in an Emergency?
Name:
_____
Last First Middle

Telephone# _____
Cell Phone#_____
Relationship to Patient_____
_____

PRIMARY INSURANCE POLICY
Insurance Co. Name _____
Policy holder's Name _____
Policy # _____
Group #_____

SECONDARY INSURANCE POLICY
Insurance Co. Name _____
Policyholder's Name _____
Policy #_____
Group #_____

Insured's Name _____
Last First Middle

Address _____
_____
City State Zip Code

Home Phone# | Business Phone#

Cell Phone# | Social Security# | Birth Date

Responsible Party for Account _____
Last First Middle

Individuals Authorized to Receive Information about **YOUR ACCOUNT:**
1) Name: _____
Last First Middle
Telephone # _____ Cell Phone #_____ Business#_____
Relationship to Patient _____

2) Name: _____
Last First Middle
Telephone # _____ Cell Phone #_____ Business#_____
Relationship to Patient _____

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly to Sandhills Family Practice, P.A.
Signed_____ Date_____

I hereby authorize Sandhills Family Practice, P.A. to furnish any information required to process my insurance claims.
Signed_____ Date_____

MEDICAL HISTORY

Check only those with which you have had a significant problem (currently or over the past year)

CONSTITUTIONAL:
____Significant (10lb weight gain/loss? _____
____Problems with appetite? _____
____Energy level too low/too high? _____
____Changes in stress/mood level? _____
____Unexplained fevers? _____
____Heat/cold intolerance? _____
____Unusual thirst? _____

EYES/EARS/NOSE/THROAT:
____Decreased hearing? _____
____Ringing or noises in ears?
_____
____Nasal congestion? _____
____Nose bleeding? _____
____Sores in mouth/bleeding gums? _____
____Impaired taste? _____
____Any visual changes? _____

NEUROLOGICAL:
____Lightheadedness/fainting? _____
____Unusual headaches? _____
____Problems w/balance? _____

CARDIOVASCULAR/RESPIRATORY:
____Chest pain? _____
____Palpitations? _____
____Shortness of breath? _____
____Swelling in legs? _____
____Awake w/sudden breathlessness? _____
____Unusual cough/sputum production?
_____

GASTRONINTESTINAL:
____Unusual nausea/vomiting? _____
____Unusual diarrhea/constipation? _____
____Change in stool? (size/color/shape)_____
____Rectal bleeding? _____
____Abdominal pain? _____
____Gas/bloating? _____
____Heartburn? _____
____Trouble swallowing/food getting stuck?
_____

GENITOURINARY:
____Difficulty or pain w/urination? _____
____Blood in urine? _____
____Sexual dissatisfaction/difficulty_____
____Difficulty controlling urine_____
____Difficulty controlling bowel movements?
_____

MUSCULOSKELETAL:
____Muscle aches/cramps? _____
____Muscle fatigue? _____
____Joint stiffness/pain/swelling? _____

SKIN:
____Unusual rashes/sores/lesions? _____
____Unusual bruising? _____

BREASTS:
____Breast pain/discharge? _____
____Lump in breast? _____

INFECTIOUS DISEASES:
____Parasites_____
____HIV_____
____Chicken Pox_____
____Hepatitis_____
____Lyme disease_____
____Whooping cough_____
____Diphtheria_____
____TB_____
____Rheumatic fever_____
____Venereal disease_____
____Meningitis_____
____Other_____

WOMEN ONLY-MENSTRUAL HISTORY:
Age at onset_____
Regular: Yes No Varies
Cycle_____(# of day from 1st day-next 1st day)
Flow: Heavy Medium Light
Any clots passed? _____
Pains/cramps? _____
Premenstrual symptoms? _____
Date of last period_____
Date of last Pap test_____Result_____
Any discharge from vagina? _____
If so, color_____amount_____
Any itching of vaginal area? _____
Other_____

PREGNANCIES:
How many pregnancies? _____
How many children born alive? _____
How many stillbirths? _____
How many cesarean sections? _____
How many miscarriages? _____Abortions? _____
Any complications with pregnancy? _____
Describe:_____

MEN ONLY:
____Enlarged prostate? _____
____Elevated PSA? _____
____Problems with Erections/orgasms?
_____
____Urethral discharge? _____

Sandhills Family Practice, P.A.

ADULT PATIENT HISTORY FORM

NAME _____ SS# _____-_____-_____ DATE _____/_____/_____

ADDRESS _____ OCCUPATION _____

PHONE: Home _____-_____-_____ Work _____-_____-_____ Cell _____-_____-_____

CHIEF COMPLAINT _____ DATE OF BIRTH _____/_____/_____

DRUG ALLERGIES:
CURRENT MEDICATIONS:

FAMILY HISTORY						
	Father	**Mother**	**Father's Parents**	**Mother's Parents**	**Siblings**	**Children**
Heart Disease						
High Blood Pressure						
Stroke						
Cancer						
Glaucoma						
Diabetes						
Epilepsy/Convulsions						
Bleeding Disorder						
Kidney Disease						
Thyroid Disease						
Mental Illness						
Osteoporosis						

HOSPITILIZATIONS OR SURGERIES			
Reason	**Date**	**Reason**	**Date**

WOMEN ONLY: Pregnant? ____Yes ____No Planning Pregnancy? ____Yes ____No

MEDICAL HISTORY

□ Headache	□ Pneumonia	□ Diabetes	□ Rheumatic Fever
□ Shortness of Breath	□ Ulcer	□ Hepatitis	□ Glaucoma
□ Heart Palpitations	□ GI Disorder	□ Anemia	□ Epilepsy/Convulsions
□ Heart Murmur	□ Lactose Intolerance	□ Arthritis	□ Bleeding Disorder
□ Chest Pain	□ Gallbladder Disease	□ Osteoporosis	□ Kidney Disease
□ Dizziness/Fainting	□ Prostate Disease	□ Hypertension (High Blood Pressure)	□ Thyroid Disease
□ Peripheral Vascular Disease	□ Bowel Irregularity	□ Depression	□ Mental Illness
□ Allergies/Hay Fever	□ Incontinence	□ Gout	□ Other (please specify)
□ Asthma/Emphysema	□ Sexual/Menstrual Dysfunction	□ Stroke	_____
□ Bronchitis	□ Venereal Disease	□ Cancer	_____

HABITS

☐ **Smoke** _____ packs daily
How long? _____
When stopped? _____

☐ **Coffee** _____ cups daily
☐ **Other Caffeine** _____
☐ **Alcohol:** Type/Amount _____

☐ **Sleep**
☐ Difficulty falling asleep
☐ Continuity disturbances
☐ Snoring
☐ Early morning awakening

☐ **Exercise Routine** _____
_____

☐ **Diet:** Salt Intake _____
Fat Intake _____

☐ **Contact with blood or body fluid at work** _____

Do you have a Living Will? ☐ Yes ☐ No

Sandhills Family Practice
Pediatric History Form
Welcome to our practice. Please answer all the questions found below to the best of your ability.

Patient Name: _____ Date: _____
Birth Date: _____ Age_____ Gender: Male or Female
Name of previous physicians/primary care provider: _____
Allergies/Reactions to any medications or vaccination: _____
Is your child taking any medications: YES or NO If so, please list below:
Name: _____ Dosage: _____
Name: _____ Dosage: _____
Girls only: Age at first menstrual period: _____

Immunizations

PLEASE BRING YOUR CHILD'S IMMUNIZATIONS RECORDS TO YOU APPOINTMENT!
Where did your child receive his/her immunizations: _____

Pregnancy & Birth

Name/Address of hospital where child born: _____
Please indicate any medical problems during pregnancy: ( ) NONE ( ) Specify: _____
Delivery by :( ) Vaginal ( ) Caesarean-Was it planned? _____ Emergency? If so, why?
Birth Weight: _____ Birth Length: _____ APGAR score: 1min. _____ 5min_____
Was your child premature: YES or NO If so, how early? _____
Is/ was your child breast fed? _____ If breast feeding, how long? _____
Is/Was your child formula fed? _____ If so, what type? _____

Family History

Please indicate with a (✔) family members who have had any of the following conditions:

Medical Condition:	Mom	Dad	Sister	Brother	Mom's Mom	Mom's Dad	Dad's Mom	Dad's Dad
Anemia								
Asthma								
Any Cancer								
Heart Attack/ Heat Disease								
Depression								
Diabetes, on insulin shots								
Diabetes, not on insulin								
Eczema								
High Cholesterol								
High Blood Pressure								
Kidney Disease								
Stroke								
Thyroid								

Medical History

REVIEW OF SYMPTOMS: Please check any current problems your child has below:

Constitutional
__Fevers/chills/excessive sweating
__Unexplained weight loss/gain

Eyes
__Squinting/ "crossed eyes/ Asymmetric gaze

Ears/Nose/Throat
__Unusually loud voice/hard of Hearing
__Mouth breathing
__Ear Infection
__Frequent runny nose
__Problems with teeth/gums

Sleep/Nightmares
__Depression
__ Nail biting/thumb sucking
__Bad temper/breath holding/ Jealousy

Skin
__Rashes
__Unusual moles

Respiratory
__Cough/wheeze
__Chest Pain

Gastrointestinal
__Nausea/vomiting diarrhea
__Constipation
__Blood in bowel movement

Genitourinary
__Bedwetting

__Pain with urination
__Discharge: penis or vagina

Cardiovascular
__Tires easily with exertion
__Shortness of breath
__Fainting

Blood/Lymph
__Unexplained lumps
__Easy bruising/bleeding

Allergy
__Hay fever/itchy eyes
__Eczema

Neurological
__Headaches

__Weakness
__Seizure
__Clumsiness

Psychiatric/Emotional
__Speech Problems

__Anxiety/Stress
__Problems with school

Musculoskeletal
__Muscle/Joint pain

Hospitalization/operations (with dates):

_____
_____
_____

History of any broken bones or severe sprains:

_____
_____
_____

SANDHILLS FAMILY PRACTICE, P.A.

Robert H. McConville, Jr., M.D. Stephen H. Cox, M.D. Parker S. McConville, M.D.

Jill Lambert, M.D. Jessica Burgert, M.D. June Peck, F.N.P.

Beth Stanfield, F.N.P. Kari Hussmann, F.N.P.

1125 Carthage Street
Sanford, NC 27330
919-774-6023

101 Church Street
Broadway, NC 27505
(919)258-6521

Sandhills Family Practice is happy to provide services for your visit today. The complete physical exam will provide evaluation and management for you based on your age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunizations(s) laboratory/diagnostic procedures.

If a significant abnormality is encountered or a pre-existing problem is addressed in the process of performing this preventive medicine service and if that problem/abnormality is significant enough to require additional time and work to evaluate and manage, then your provider may charge you for an office visit in addition to a charge for the physical.

If you know your insurance will not cover this extra charge, you may wish to discuss any problems you may be having at a different office visit on another day, so that the visit will not be denied by insurance.

Sandhills Family Practice prides itself on quality patient care and we appreciate you choosing our practice for your health care needs.

_____
Patient's Signature

_____
Date

SANDHILLS FAMILY PRACTICE, P.A.

Medical Record Release

1125 Carthage Street
Sanford, NC 27330
(919) 774-6023

101 Church Street
Broadway, NC 27505
(919) 258-6521

Date: _____

Records From: _____
_____
_____

Records To: _____
_____
_____

____The entire medical record
____Medical data related to:

( )Specific condition(s): _____
( )Specific dates of service: _____
( )Specific test(s): _____

Patient's Name: _____
Guardian's Name: _____
Date of Birth: _____
Patient/Guardian's Signature: _____

Witnessed By: _____

Patients transferring or needing medical records for personal use will be billed by HealthPort in accordance with HIPPA guidelines and statues.

AUTHORIZATION FOR USE OF DISCLOSURE PROTECTED HEALTH INFORMATION

I, _____ the above identified patient, or my legal representative, herby authorizes use of disclosure of protected health information to/from **SANDHILLS FAMILY PRACTICE, P.A.** including all records, x-rays, abstracts and excerpts of all records, mental health records and/or evaluations and any other information which you may possess relating to the examination, diagnosis, prognosis, care and treatment, billing or opinion rendered concerning any and all conditions that the above-identified **PATIENT** has had in the past, may have now and in the future. I understand that the information used or disclosed may be subject to re-disclosure by **SANDHILLS FAMILY PRACTICE, P.A.** and would then no longer be protected by federal privacy regulations.

SANDHILLS FAMILY PRACTICE, P.A.

Robert H. McConville, Jr., M.D. Stephen H. Cox, M.D. Parker S. McConville, M.D.

Jill Lambert, M.D. Jessica Burgert, M.D. June Peck, F.N.P. Beth Stanfield, F.N.P.

1125 Carthage Street
Sanford, NC 27330
(919) 774-6023

101 Church Street
Broadway, NC 27505
(919) 258-6521

NO SHOW POLICY

Patients are seen by appointment. We realize your time is valuable and we do our best to honor your appointment time. If you are unable to keep your appointment, we appreciate a 24 hour notice of cancellation. We reserve the right to charge for missed appointments.

Here is our policy:

- The **FIRST TIME** a patient does not show for their appointment the staff will send you a letter.
- The **SECOND TIME** a patient misses an appointment there will be a **$5.00 charge**.
- The **THIRD TIME** a patient misses an appointment there will be a **$10.00 charge.**
- On the **FOURTH TIME** a patient misses an appointment, we reserve the right to ask you to leave the practice.

You missed your appointment with _____ on _____

Please call our office at (919) 774-6023 and reschedule your appointment.

Thank you.

Sandhills Family Practice, P.A.
Patient Information and Financial Policies
(We require that you read and sign this document prior to receiving treatment.)

It is the policy of this office to help keep your health care costs as low as possible and to reduce wait times. To do this, we need to keep our billing costs to a minimum. Please help us in the following ways:

- Always bring your current health insurance card to the office.
- Please notify us at time of check-in of any changes in insurance, address, telephone or family status.
- Please pay your co-pay or deductible at the time of service at check-in.
- You will be expected to pay in full if:
  - ✓ You do not have insurance,
  - ✓ Sandhills Family Practice, P.A. does not participate with your health plan,
  - ✓ You are unable to present a valid member identification card from your insurance carrier at your visit, or
  - ✓ We are unable to verify your insurance coverage.
- You should receive a bill for any other patient responsibility within 30 days; and/or an explanation of benefits (EOB) from your insurance company. If you do not, please contact the billing office at **919-774-0623, option 6.**

Statements: If you have a balance on your account, we will send you a statement. It will show separately the previous balance, any new charges to the account, and any payment/credits applied to the account during the month.
Payments: Unless other arrangements are approved by us in writing, the balance on your statement is due and payable when the statement is issued, and is past due if not paid within ten (10) days.
Payment Options if you have Insurance: We are required by our insurance contracts to collect all co-pays and other patient responsible amounts, at the time of service. Any co-pays that are not paid on the day of the visit may be subject to a $10.00 co-pay processing fee. To assist you, we accept cash, checks or credit/debit cards. We reserve the right to reschedule your appointment if you are not prepared to pay your co-pay or patient account balance. ***If you have not met your deductible*** – we will estimate the expected insurance payment for your visit and request that amount at the time of service – this is an estimate only – you may receive a statement with additional balances after your visit.
Payment Options if you have No Insurance: Unless arrangements are made in advance, we will collect payment at your visit. Your choice is to pay by cash, check, or credit/debit card on the day that treatment is given.
Insurance: It is the responsibility of the cardholder to know what their eligibility and coverage is with their insurance carrier. If this is not known, we suggest that you verify coverage limitations prior to being treated – to assist you we will provide a courtesy telephone. Although we will estimate what your insurance company may pay for your visit, it is the insurance company that makes the final determination of your financial obligations and eligibility for services. You agree to pay any portion not covered by your insurance. If your insurance company has not processed your account within 90 days from the date of service, the balance will automatically be sent to you. Your signature on this form indicates that you authorize Sandhills Family Practice, P.A. to bill your insurance company directly for services rendered and for your insurance company to make payment directly to Sandhills Family Practice, P.A.
Past Due Accounts: If your account becomes past due, we will take the necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collection costs including a collections fee that may be added to the account. If we need to send the account balance to collections because of non-payment of the account, our physicians may no longer be able to provide care. In this case, the person responsible for the account will be notified of this by certified mail and given adequate time to find a new medical provider. All accounts sent to the collection agency will be reported to the Credit Bureau and may be subject to a collection fee of $50.
Returned Checks: There is a fee (currently $25.00) for any checks returned by the bank. This amount may change without notice.
Insurance Release: I understand that my health plan may not be liable for service rendered if any of the following conditions apply:
♦ I have a pre-existing condition or other diagnosis that may not be covered by my plan;
♦ Sandhills Family Practice, P.A. does not participate in my health plan;
♦ I have not met the deductible under my health plan contract;
♦ Routine services may not be covered by some insurance plans.
On-the-Job Injuries/Accidents: If the reason for your visit is an accident or injury while on the job,

please know that we will submit the bill directly to your employer or your employer's workers' compensation carrier – *the bill will not be covered unless your employer files a claim to the carrier* – it will remain your responsibility until a valid claim is filed by your employer.

Copies and Transfer of Records: All past due amounts will be collected before medical records are copied or transferred. A nominal fee is assessed to cover copy costs. We do charge $15.00 for the completion of forms and other paperwork done at the patient's request **and the fee must be paid in advance**.

Effective Dates: Once you have signed this agreement, you agree to all of the terms and conditions contained herein for this and any future visits, and the agreement will be in full force and effect. Patients who are scheduled for specialized tests have extended time and/or medication that has been scheduled and/or ordered specifically for them. Failure to keep these types of appointments, with no prior notice to the practice, results in significant and unrecoverable costs to Sandhills Family Practice, P.A. In the event that you cannot keep one of these appointments, 24 hours notice is required to avoid a "No Show" fee being charged to your account. Therefore, knowing this, I request that services be performed and I agree to be responsible for any charges incurred. I understand that if I fail to make payment when due and my account becomes delinquent or is turned over to a collection agency for collections, the undersigned shall pay all collection agency fees, and risk being dismissed from the physician care of Sandhills Family Practice, P.A.

Prescription Renewals: All prescription renewals must be addressed directly with your pharmacy. Simply call your pharmacy with the medication(s) that need to be refilled and they will contact our office directly**. No "walk-in" requests for refills will be honored nor will we call in prescriptions during an office visit**. Many times there are additional refills remaining. It may take up to 48 hours for the pharmacy to reach us, so please allow ample time before you run out of medication completely. Check back with the pharmacy as to whether the prescription has been filled. If a prescription needs a prior authorization from an insurance company, it will be handled in a timely manner. All insurance companies vary in the length of time it takes to process authorizations. Our office will not refill a prescription for a patient who has not been seen in the last year; please call to make an appointment. It is not appropriate to refill prescriptions for patients who have not had adequate follow-up visits. It is important for our providers to be able to monitor patient progress and use of medication. No refills will be called in after hours, weekends or holidays. **Refills of controlled substance medications will be made only during office hou**rs, Monday through Friday, and either during a scheduled office visit or as determined by your physician. Prescriptions for narcotics or anti-anxiety (sedatives) drugs will not be mailed. In addition, prescriptions for narcotics require a follow-up appointment every 30-90 days. Should you feel that you need a prescription or refill other than during office hours, you may need to be seen in an emergency room and evaluated by the attending physician. For safety reasons, we will only fill your prescriptions with the **ONE pharmacy** you designate, unless you notify us that you are changing to a different pharmacy. You must have ***only one*** designated pharmacy in your patient records with us. **Refills will not be made** if you "run out early," or "lose a prescription including one for controlled substances such as narcotics or sleep meds," or "spill or misplace" your medication. You are responsible for taking the medication in the dose prescribed and for keeping track of the amount remaining. **Refills will not be made** as an "emergency" such as on a Friday afternoon because you suddenly realize you will run out tomorrow. You must call at least 48 hours ahead if you need assistance with a refill. **You are responsible for the controlled substance medications prescribed to you.** If your prescription is lost, misplaced, or stolen, or if you "run out early," please understand that **it will not be replaced.**

SAMPLE DRUGS WILL ONLY BE DISPENSED DURING REGULARLY SCHEDULED APPOINTMENTS. PLEASE DO NOT CALL THE OFFICE FOR SAMPLES.

I have read this Patient Information and Financial Policy, as outlined, and understand that I am ultimately responsible for the charges incurred by me or by my child/children as their legal parent or guardian. This is an agreement between Sandhills Family Practice, P.A., as creditor, the Patient, Guardian/Guarantor, or Parent as debtor, named on this form. In this agreement, the words "you," "your," and "yours" mean the patient/debtor. The word "account" means the account that has been established in your name to which charges are made and payments credited. The words "we," "us," and "our" refer to Sandhills Family Practice, P.A. By executing this agreement, you are agreeing to pay for all services that are received and to all of the terms outlined above.

_____ _____

Patient/Guardian Signature/Date Patient/Guardian Name (PRINTED)

PLEASE NOTE: A signed copy of this agreement will remain in your medical record chart. You may request a signed copy for your records.

Policies and Guidelines

Prescription Policy and Medication Guidelines

- The first step to refilling your prescription is to call your pharmacy and ask that a refill request be faxed to our office.
- Some medications can be called into the pharmacy, and other types such as medications for pain, anxiety, and ADHD, require that you pick them up from our office. Please check with your provider about your specific medications.
- Prescriptions take up to 72 hours to be processed and refilled. Please allow at least two to three days to get the medication filled. Please plan ahead if the prescription is due on a weekend or holiday, and give us enough time to prepare the prescription.
- Requests for same day or walk-in refills (requested by walking into the clinic) will not be honored. You must give the staff 72 hours to prepare the prescription. A request that is called in or faxed after 4:00 p.m. will be considered a following-day request.
- Renewals and refills will be handled Monday through Friday between 8:00 a.m. and 4:00 p.m. only. No refills or adjustments are made after business hours.
- There will be no refills after hours by our on-call physician or providers for any reason. The on-call provider is to be called for illnesses and emergencies only.
- Change to your medication treatment plan (increasing or changing medications) may require a follow-up visit for re-evaluation.
- Prescriptions for pain medications or anxiety medications will not be changed without the patient returning the rest of the original prescription to the office for identification, counting and disposal at the time of the next follow-up appointment.
- If your prescription for pain medications or anxiety medications runs out early for any reason (for example, you take more than is prescribed or you lose your prescription/medication), your provider reserves the right not to prescribe extra medication for you or give you an early refill. If you run out of your pain or anxiety medicine early, you will have to wait until the next prescription is due.
- Please note: In order for a refill to be processed, an office staff member will need to verify the prescription, verify that the refill is due, and speak to you to find out whether the medication is working, if there are any side effects, and to make sure that you have a follow-up appointment with one of our providers.
- Follow-up appointments are required at least every three months (90 days) if you are receiving pain medication or ADD/ADHD medications.
- Common potential side effects of an opioid (pain medication/narcotic) therapy may include nausea, constipation, sweating, itching, rash, increased drowsiness and allergic reactions.
- If you think that you are having an allergic reaction to a medication, call our office immediately or go to the nearest emergency room.

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.

Sandhills Family Practice, P.A. is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Policies and Guidelines

We take your privacy very seriously.

Disclosure of Your Health Care Information

Treatment

We may disclose your health care information to other healthcare professionals, team coaches, immediate family members to include spouse, parents, adult children, guardians and insurance companies for the purpose of treatment, payment or healthcare operations.

"On occasion, it may be necessary to seek consultation regarding your condition from other healthcare providers associated with Sandhills Family Practice, P.A."

"It is our policy to provide a substitute health care provider, authorized by Sandhills Family Practice, P.A. to provide assessment and/or treatment to our patients, without advance notice, in the event of your primary health care provider's absence due to vacation, sickness, or other emergency situation."

Payment

We may disclose your health information to your insurance provider for the purpose of payment or health care operations.

"As a courtesy to our patients, we will submit an itemized billing statement to your insurance carrier for the purpose of payment to Sandhills Family Practice, P.A. for health care services rendered. If you pay for your health care services personally, we will, as a courtesy, provide an itemized billing to your insurance carrier for the purpose of reimbursement to you. The billing statement contains medical information, including diagnosis, date of injury or condition and codes which describe the health care services received."

Workers' Compensation

We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

Emergencies

We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

Public Health

As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect,

reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

Judicial and Administrative Proceedings

We may disclose your health information in the course of any administrative or judicial proceeding.

Law Enforcement

We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

Deceased Persons

We may disclose your health information to coroners or medical examiners.

Organ Donation

We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

Research

We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

Public Safety

It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

Specialized Government Agencies

We may disclose your health information for military, national security, prisoner and government benefits purposes.

Phone contact

We may need to contact you by phone. If you are not home we will proceed as follows:

"In the event we call your home and you are not at home, we leave a message on your answering machine or with the person answering the phone. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment."

Policies and Guidelines

Your Health Information Rights

You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that Sandhills Family Practice, P.A.is not required to agree to the restriction that you requested.

You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.

You have the right to inspect and copy your health information.

You have a right to request that Sandhills Family Practice, P.A. amend your protected health information. Please be advised, however, that Sandhills Family Practice, P.A.is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.

You have a right to receive an accounting of disclosures of your protected health information made by Sandhills Family Practice, P.A.

You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

Changes to this Notice of Privacy Practices

Sandhills Family Practice, P.A .reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, Sandhills Family Practice, P.A. is required by law to comply with this Notice.

Sandhills Family Practice, P.A. is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact the privacy officer by calling our office at 919-774-6023. If the privacy officer is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

Complaints

Complaints about your Privacy rights, or how Sandhills Family Practice, P.A. has handled your health information should be directed to the privacy officer by calling this office at 919-774-6023. If the privacy officer is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

Policies and Guidelines

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201
This notice is effective as of 04/29/03.

SANDHILLS FAMILY PRACTICE, P.A.

Robert H. McConville, Jr., M.D.
Dana L. Garrett, M.D.
Stephen H. Cox, M.D.
Keely L. Burns, M.D.

1125 Carthage Street
Sanford, NC 27330
(919) 774-6023

101 Church Street
Broadway, NC 27505
(919) 258-6521

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES:

Patient Name:_____

Date:_____

Signature:_____

If signature is not that of the patient, indicate below the relationship of person signing for the patient (e.g., Parent, Guardian):_____

If patient or patient's representative does not sign, indicate the reasons why signature could not be obtained: _____

_____

_____ **Date:**_____

Name of Practice Staff Member