# Welcome!

## Thank you for choosing us as your Medical Home!

*Dear Patient:*

The staff at Low Country Health Care System, Inc. would like to take this opportunity to thank you for choosing us as your medical home. As your provider of health care, we look forward to serving you. We hope together, we can build a relationship that will ensure you receive the highest quality care and service.

A "patient centered medical home" is a medical office where a team of health care professionals work together to provide a new type of care to patients. Having a medical home feels like having an old style family doctor, but with a team of professionals, using modern knowledge and technology, to provide the best possible care for you in their office.

As a patient centered medical home, LCHCS's staff is dedicated to managing your healthcare.
• Our team of health care professionals will provide you with the latest ways to maintain your health with proven methods and self-management tools.
• LCHCS will have dedicated staff to help arrange referrals to outside sources such as specialists or labs and ensure that we receive your reports/results during your medical visits.
• Your team may include a doctor, nurse, as well as other health professionals, like a pharmacist or behavioral health therapist.

**After Hours Contact**
As your medical home, your care team is available 24/7. If you need care after hours, you can communicate with your care team at anytime by phone. To contact a Provider after office hours, please call any of our office numbers listed in this packet and our call services will direct you to the on-call provider. If you need assistance in Spanish, you can dial 1-803-244-9359.

*Si necesita asistencia en español, puede marcar el 1-803-244-9359.*

*Sincerely,*

Ashley L. Barnes, MBA, PhD
Chief Executive Officer

LOW COUNTRY HEALTH CARE SYSTEM
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# Visit our Patient Portal

## Test Results, Visit Summaries & More

## @ www.LCHCS.com

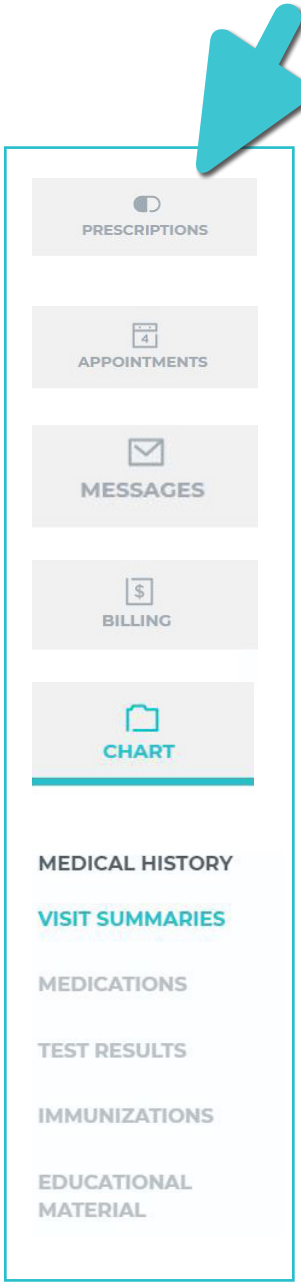
### Before you leave today, ask our Front Office Staff about signing up for your Online Patient Portal!

As a valued patient, we hope you will enjoy the convenience of online access to our office. We invite you to join our patient portal. After joining, you will have 24/7 access to view your appointment information, visit summaries, billing information, prescriptions and more.

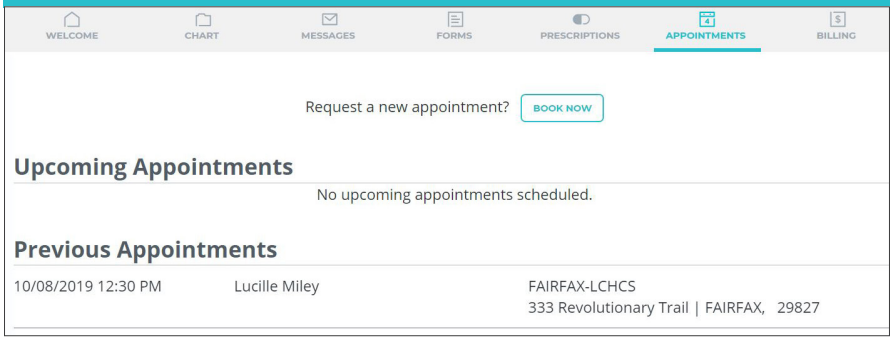
**To register, go to www.LCHCS.com & click on patient portal.**

Your ***Username*** is your email address on file with our office and you will use the ***temporary password*** given to you by the office to login. After logging in, you will need to change your password to something of your choice.

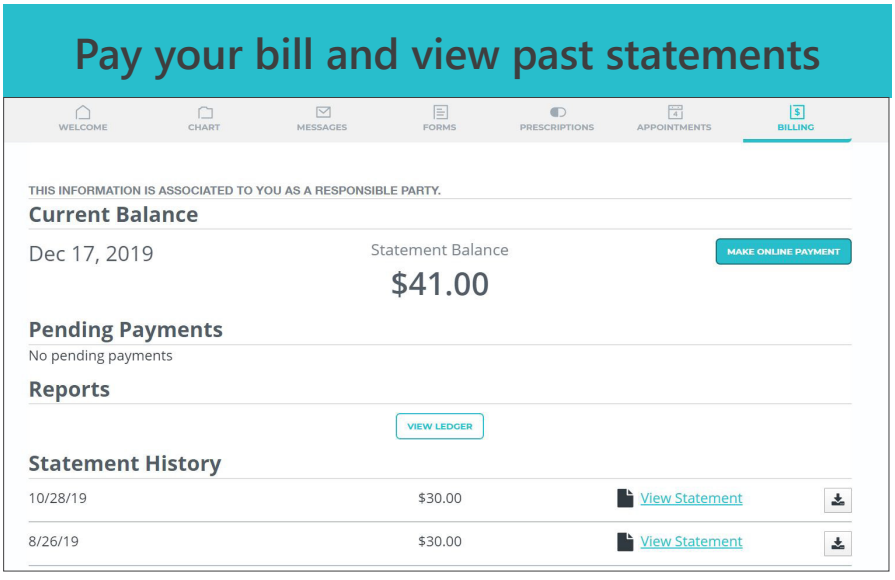
**TEMPORARY PASSWORD: _____**




## View Upcoming Appointment Information and Print Visit Summaries




## Pay your bill and view past statements

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# LOW COUNTRY HEALTH CARE SYSTEM

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## ABOUT US

**Low Country Health Care** provides cost-effective, high quality, comprehensive medical care in a comforting family environment to patients of all ages. From annual exams to minor emergencies and unforeseen illnesses, our offices are fully equipped to provide the full array of health care services to all individuals, regardless of ability to pay.

## OUR VISION

**Accessible, Quality Health Care for All.**

Our mission is to be the healthcare provider of choice, delivering superior customer service and compassionate, high-quality care.

## SERVICING ALL PATIENTS

This practice services all patients regardless of ability to pay. Discounts for essential services and medications purchased at one of our pharmacies are offered on a sliding fee scale, based on family size and income in relation to the federal poverty guidelines. The Sliding Fee Scale is available to all patients, whether you have insurance or not.

- **We accept most major insurances**
- **We accept Medicare and South Carolina Medicaid**
- **We offer a sliding fee based on family size & income**
- **We offer Affordable Care Act assistance at select locations to assist with application submissions**

For resources and health education please visit:
www.LCHCS.com

## OUR LOCATIONS

### Low Country Health Care System
*(Medical Care & Administrative Offices)*
**803.632.2533 | M-F 8AM - 5PM**
**Open Late on Tuesday 8AM - 8PM**
333 Revolutionary Trail, Fairfax, SC 29827

### Williston Family Medicine
**803.266.0060 | M-F 8AM - 5PM**
**Closed from 12:00 - 1:00 for Lunch**
13649 Church Street, Williston, SC 29853

### Family Medical Center of Blackville
**803.284.1045 | M-F 8AM - 5PM**
**Closed from 12:00 - 1:00 for Lunch**
130 North Baker Street, Blackville, SC 29817

### Barnwell Family Medicine
**803.259.5762 | M-F 8AM - 5PM**
**Open Late on Monday & Tuesday 8AM - 8PM**
86 Wren Street, Barnwell, SC 29812

### Barnwell Family Specialty Services Women's Health Center
**803.259.5762 | M-F 8AM - 5PM**
**Closed from 12:00 - 1:00 for Lunch**
124 Wren Street, Barnwell, SC 29812

### Barnwell Pediatrics
**803.259.7337 | M-F 8AM - 5PM**
**Saturday 8:30AM - 10:30AM**
10706 Marlboro Avenue, Barnwell, SC 29812

### Padgett Family Practice
**803.245.2433 | M-F 8AM - 5PM**
526 North Street, Bamberg, SC 29003

### Bamberg Specialty Services
**803.956.6100 | M-W 8AM - 5PM**
**Closed from 12:30 - 1:30 for Lunch**
185 McGee Street, Bamberg, SC 29003

### Aiken Family Medicine
**803.306.1433 | M-F 8AM - 5PM**
**Closed from 1:00 - 2:00 for Lunch**
209 Abbeville Ave, NW, Aiken, SC 29801

**We have Pharmacy locations at Barnwell Family Medicine, Bamberg Specialty Services, and our Fairfax location. Pharmacy Hours are Monday - Friday from 8:30 to 5:00 and closed from 12:30 to 1:30 for lunch.**

## SERVICES

Low Country Health Care System provides primary, acute and chronic care, for all stages of life: Pediatrics, Adolescents, Adults and Geriatrics. From annual exams to minor emergencies and unforeseen illnesses, our office is equipped to provide a variety of services to our patients.

- **Family Medical Services** *(All Stages of Life)*
- **Pediatric Care**
- **Adult & Pediatric immunizations**
- **Pediatric Developmental and Behavioral Health**
- **Women's Health Care (***Pap Smears, Well Women Exams)*
- **Prenatal Care**
- **OB Ultrasound**
- **Family Planning Services**
- **X-Ray Services**
- **Laboratory Services** *(Labs Drawn on Site)*
- **Nutrition Counseling**
- **Psychiatric and Behavioral Health Services**
- **Medications for Opioid Use Disorder**
- **Infectious Disease Specialist**
- **Bone Density**
- **Minor Surgery**
- **Ophthalmology** *(Services Provided by Arrangement)*
- **On-Site Pharmacies with 340B Pricing**
- **Translation Services** *(All Languages Available)*
- **Transportation**
- **Late Night Clinic Hours**
- **Saturday Hours at Barnwell Pediatrics**
- **Sliding Fee Scale for Uninsured and Under-insured** *(Based on Federal Poverty Guidelines)*
- **AIDS & HIV Prevention, Treatment and Support**
- **Indigent Medication Program**
- **Healthy Families of America**
- **Migrant Program**
- **Reach Out and Read** *(Books for Children)*
- **Care Coordination**

## SPECIALTIES:

Among our full array of primary care options. Low Country Health Care has a robust variety of specialty care.

*Some of these include:*

### Mental Health

Low Country has a team dedication to mental health care. We have an on-site Social Worker, Psychiatric Nurse Practitioner, Psychiatrist, and Pediatric Behavioral Health Specialist.

### Women's Health

Low Country offers Women's Health services to include Prenatal Care, Pap Smears, Well Women Exams, OB Ultrasound and Family Planning Services.

### Substance Use Disorders

Medications for Opioid Use Disorder (MAT or MOUD) combines behavioral therapy and medications to treat substance use disorders.

### Healthy Families America

Healthy Families America is a home visiting model created to address high rates of child abuse occurrences to children under five. LCHCS has a team focused on enrolling new families from prenatal stages through 3 months of age and has an on-site Nurse Midwife to provide care.

### Ryan White (HIV & AIDS) Services

Early Intervention Services provides services and resources to people living with HIV & AIDS. The program provides high quality, confidential patient-centered environment to everyone regardless of race, gender or economic status. There are options to help pay for care and treatment for eligible South Carolinians living with HIV & AIDS who are uninsured or under insured.

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**Visit our Patient Portal Online!**
www.lowcountryhealthcaresystem.com

**www.LowCountryHealthCareSystem.com**

# PATIENT DEMOGRAPHIC FORM

**Date:** _____

Patient's Last Name: _____ First: _____ MI: _____
Date of Birth: _____ SS#: _____
Street Address: _____
City: _____ State: _____ Zip: _____
Home Phone Number: _____ Work/Other Phone: _____
Email: _____

Insurance Plan: _____ ID: _____

Race ***(Circle One):*** Asian Native Hawaiian Other Pacific Islander
White Black/African America American Indian/Alaska Native
More than one race

Ethnicity ***(Circle One):*** Hispanic/Latino Other: _____

Language: _____

Gender Identity ***(Circle One):*** Male Female Transgender Male Transgender Female
Do not disclose

Sexual Orientation ***(Circle One):*** Heterosexual (Straight) Lesbian or Gay Bisexual
Do not disclose

Marital Status: Married Single Widowed Divorced Separated

Student Status: Full Time Part Time

Employment Status: Full Time Part Time Retired Self Employed

Name of Employer or School: _____

Veteran: ***(Circle One):*** Yes No

Family Size: _____

Household Income: ***(Circle One):*** Less than $13,590 $13,591-$18,754 $18,756-$20,385
$20,386 - $27,180 Greater than $27,180

# PATIENT DEMOGRAPHIC FORM (pg. 2)

Date: _____

**RESPONSIBLE PARTY** ***If patient is responsible party, check here _____ and skip this section***

Name: _____

Date of Birth: _____ SS#: _____

Employer: _____ Phone: _____

**EMERGENCY INFORMATION**

***Please list a non-household family, friend, or neighbor to contact in case of any emergency.***

Name: _____ Phone: _____

Address: _____ Relationship to patient: _____

***Insurance Authorization and Treatment Consent***

*I hereby authorize LCHCS facilities to perform any exam, lab work, x-rays, and treatment. I also authorize them to furnish any and all information, physical and mental, concerning my illness and treatments to obtain reimbursement from health care benefits administrators or to other physicians and/or medical facilities for the continuum of my care. I understand that I am personally responsible for my financial amount not covered by my health insurance carrier at the time of service. I permit a copy of this authorization to be used in the place of the original. I authorize release of any information acquired in the course of examination or treatment of myself and allow a photocopy of my signature to be used. I authorize the release of any medical or other information necessary to process my insurance claims. I authorize the release of any medical benefits to myself or to the party who accepts assignment below. I authorize payment of medical benefits to the undersigned physician or supplier of medical services.*

*I hereby give consent for my picture to be taken for identification purposes. It may be updated annually.*

***Insurance Authorization and Treatment Consent for Minors/Dependents***

***I authorize Low Country Health Care System to provide medical care reasonably by today's standard for my child/children/dependent****. This consent is valid until it is revoked in writing.* ***I authorize release of any information acquired in the course of examination or treatment of my child/children/dependent*** *and allow a photocopy of my signature to be used. I authorize the release of any medical or other information necessary to process insurance claims. I authorize the release of any medical benefits to myself or to the party who accepts assignment below. I authorize payment of medical benefits to the undersigned physician or supplier of medical services.*

**I have read and understand the above policies of Low Country Health Care System, Inc.**

_____ _____

***Signature of Patient or Legal Guardian*** ***Date***

_____ _____

***Print Patient's Name*** ***Print Name of Legal Guardian, if applicable***

# CONSENT FOR USE & DISCLOSURE of HEALTH INFORMATION

***(PHI/HIPAA NOTICE)***

*I hereby give my consent for* ***Low Country Health Care System (LCHCS)*** *to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). (The Notice of Privacy Practices provided by LCHCS describes such uses and disclosures more completely.)*

I have the right to review the Notice of Privacy Practices prior to signing this consent. LCHCS reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to LCHCS, PO Box 990, Fairfax, SC 29827 or by calling any of our offices.

With this consent, LCHCS may call or text my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, LCHCS may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

With this consent, LCHCS may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

I have the right to request that LCHCS restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow LCHCS to use and disclose my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, LCHCS may decline to provide treatment to me.

_____ _____

*Signature of Patient or Legal Guardian* *Date*

_____ _____

*Print Patient's Name* *Print Name of Legal Guardian, if applicable*

## Pharmacy Preference

**Date: _____**

_____ in _____
*Pharmacy* *Town*

is my choice for e-RX. I authorize _____ to obtain e-Med history.
*Pharmacy*

_____ _____
*Signature of Patient or Legal Guardian* *Date*

_____ _____
*Print Patient's Name* *Print Name of Legal Guardian, if applicable*

# CONSENT TO SHARE MY HEALTH INFORMATION

***with family members or others***

Date: _____

Patient Name: _____

Date of Birth: _____ Phone: _____

Address: _____

LCHCS Provider: _____

Please complete the following for person(s) you authorize to be able to call our office and/or accept phone calls from our office related to your medical care (for example, can they receive calls regarding lab results, appointment scheduling, etc.)?

| Name: | | | Name: | | | Name: | | |
|---|---|---|---|---|---|---|---|---|
| Relationship: | | | Relationship: | | | Relationship: | | |
| Phone: | | | Phone: | | | Phone: | | |
| Appointments | YES | NO | Appointments | YES | NO | Appointments | YES | NO |
| Billing | YES | NO | Billing | YES | NO | Billing | YES | NO |
| Test Results | YES | NO | Test Results | YES | NO | Test Results | YES | NO |
| Medical Info | YES | NO | Medical Info | YES | NO | Medical Info | YES | NO |

I understand by signing this request that my protected health information can be communicated with the listed individuals. This consent to share information will be kept as a permanent part of my medical record to allow multiple staff members to communicate with others directly involved in my care. I understand that my health care providers will use judgement in determining the minimum amount of information that must be shared.

I, _____ decline LCHCS to release any information to anyone other than myself, even in emergency situations.

_____ _____

*Signature of Patient or Legal Guardian* *Date*

_____ _____

*Print Patient's Name* *Print Name of Legal Guardian, If Applicable*

THIS FORM MUST BE SIGNED IN PERSON BY THE PATIENT OR A LEGAL GUARDIAN AT THE FRONT DESK OF A LOW COUNTRY HEALTH CARE OFFICE AND CANNOT BE SIGNED ELECTRONICALLY. THANK YOU.

# PAYMENT POLICY

**1. Insurance.** We participate in most insurance plans, including Medicare and South Carolina Medicaid. If you are not insured by a plan in which we participate, payment in full is expected at each visit. If you are insured by a plan in which we participate, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage. In addition, you may qualify for our Sliding Fee Program which could reduce your portion for your visit. Please see #3 for more details.

**2. Co-payments and deductibles.** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit. All Sliding Fee co-payments are required at the time of service.

**3. Uninsured.** If you are not covered by any insurance policy, then you may qualify for our Sliding Fee Program. This program greatly reduces your portion for the services you receive in our office. The discount is calculated based on the Federal Poverty Level Guidelines including the family size and the total household income. Verification of income is requested during the screening process. If you do not qualify for our Sliding Fee Program and can pay for your services at the time of service, then you may be eligible for a time of service discount.

**4. Non-covered services.** Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

**5. Proof of insurance.** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

**6. Claims submission.** We will submit your claim and assist you in any way we reasonably can to help get your claim paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

**7. Coverage changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.

**8. Method of Payments.** Cash, check, or credit card are all acceptable forms of payment.

***I have read and understand the payment policy and agree to abide by its guidelines.***

_____ _____

***Signature of Patient or Legal Guardian*** ***Date***

_____ _____

***Print Patient's Name*** ***Print Name of Legal Guardian, if applicable***

# TELEMEDICINE PATIENT CONSENT FORM

I, _____, agree to participate in a telemedicine evaluation. By signing this agreement, I authorize the electronic transmission of my medical information and/or videoconference session so that it can be viewed by a doctor and other persons involved in my medical or mental health care. [Note: The likelihood of this transmission being intercepted by persons other than those at the consulting site is extremely small].

I understand that I can withdraw my permission at any time and that I do not have to answer any questions that I consider to be inappropriate or am unwilling to have heard by other persons. I understand that if I do not choose to participate in a telemedicine session, no action will be taken against me that will cause a delay in my care and that I may still pursue face-to-face consultation.

I understand that as with any technology, telemedicine does have its limitations. There is no guarantee, therefore, that this telemedicine session will eliminate the need for me to see a specialist in person.

I understand that medical records of telemedicine services will be kept at both the referring site facility and the consulting site facility.

I understand that some or all of my medical information may be used for teaching or educational purposes.

I agree to have my telemedicine medical records reviewed for the purposes of evaluation (data collection, analysis and presentation in verbal or written format at scientific meetings). I understand that any presentation will not identify me by name or other identifiable markers. **DECLINE _____ (initials)**

If clinical information regarding HIV status is included in my medical record for purposes of the telemedicine evaluation, I agree to the collection of these data for research purposes. **DECLINE _____ (initials)**

FOR DEMONSTRATIONS ONLY: I agree to permit other persons who are not involved in my medical care to observe my evaluation. I understand that I may withdraw this permission at any time during my evaluation. **DECLINE _____ (initials)**

_____ _____

***Signature of Patient or Legal Guardian*** ***Date***

_____ _____

***Print Patient's Name*** ***Print Name of Legal Guardian, if applicable***

___ *CHECK HERE AND SIGN BELOW FOR WITHDRAWAL ONLY*
*I have chosen not to participate further in telemedicine evaluations.*

_____ _____

*Signature of Patient or Legal Guardian* *Date*

# HEALTH HISTORY

Date: _____

Patient Name: _____ Date of Birth: _____

Reason for today's visit: _____

***SYMPTOMS: Please check if you have had any of these symptoms recently:***

| **GENERAL:** | |
|---|---|
| Appetite Change | |
| Weight change | |
| Weakness | |
| Bleeding | |
| Fever | |
| Chills | |
| Recent Injury | |
| Infections | |
| **ABDOMEN:** | |
| Abdominal Pain | |
| Bloating | |
| Indigestion | |
| Nausea | |
| Vomiting | |
| Vomiting Blood | |
| Diarrhea | |
| Constipation | |
| Black Tarry Stool | |
| Blood in Stool | |
| Excessive Gas | |
| **NEUROLOGY:** | |
| Headaches | |
| Dizziness | |
| Passing Out | |
| Memory Loss | |
| Numbness | |
| Tingling | |
| Clumsiness | |
| Double Vision | |

| **EYE, EAR, NOSE, THROAT:** | |
|---|---|
| Vision Change | |
| Hearing Loss | |
| Nose Bleed | |
| Unusual Sneeze | |
| Sore Throat | |
| Swallowing Problems | |
| Ear Pain | |
| Facial Pain | |
| **MUSCLE/JOINTS:** | |
| *(Pain, Weakness or Numbness):* | |
| Arms | |
| Back | |
| Feet | |
| Hands | |
| Hips | |
| Neck | |
| Shoulders | |
| **URINARY SYSTEM:** | |
| Painful Urination | |
| Frequent Urination | |
| Urgency in Urination | |
| Leaking Urine | |
| Unable to Urinate | |
| Straining to Urinate | |
| Dark Urine | |
| Blood in Urine | |
| | |
| | |
| | |

| **LUNGS:** | |
|---|---|
| Cough | |
| Short of Breath | |
| Coughing Blood | |
| **HEART:** | |
| Chest Pain | |
| Palpitations | |
| Ankle Swelling | |
| **SKIN:** | |
| Rash | |
| Bruising | |
| Itching | |
| Sores | |
| **MEN'S HEALTH:** | |
| Breast Lump | |
| Erection Difficulty | |
| Lump in Testicle | |
| Penis Discharge | |
| Sore on Genitals | |
| **WOMEN'S HEALTH** | |
| Bleeding Between Periods | |
| Breast Lump | |
| Severe Menstrual Pain | |
| Hot Flashes | |
| Nipple Discharge | |
| Painful Intercourse | |
| Vaginal Discharge | |
| Bleeding after Menopause | |
| Genital Sores | |
| | |

1. Have you ever felt you should cut down on drinking Alcohol (and/or Drug use)? __ YES __ NO
2. Have people annoyed you by criticizing your drinking (and/or Drug use)? __ YES __ NO
3. Have you ever felt bad or guilty about drinking (and/or Drug us)? __ YES __ NO
4. Have you ever had a drink first thing in the morning or to get rid of a hangover? __ YES __ NO
5. In the last 2 weeks or more, have you felt down, blue or bad about yourself? __ YES __ NO
6. In the last 2 weeks or more, have you had trouble performing your job or taking an interest in activities you normally enjoy? __ YES __ NO
7. Have you ever felt physically threatened by a member of your household? __ YES __ NO
8. Do you have a gun in your household? __ YES __ NO
9. Do you wear a seat belt each time you are in a vehicle? __ YES __ NO
10. Do you exercise regularly? __ YES __ NO

## HEALTH HISTORY (Pg. 2)

Date: _____

Patient Name: _____ Date of Birth: _____

| FAMILY / PERSONAL HISTORY (Please check if you or your blood relatives have any of the following): | | | | | | |
|---|---|---|---|---|---|---|
| **DISEASE** | **SELF** | **MOTHER** | **FATHER** | **BROTHER** | **SISTER** | **GRANDPARENT** |
| Arthritis | | | | | | |
| Asthma, Hay Fever | | | | | | |
| Chemical Dependency | | | | | | |
| Cancer | | | | | | |
| Diabetes | | | | | | |
| Heart Attack | | | | | | |
| Hypertension | | | | | | |
| Strokes | | | | | | |
| Kidney Disease | | | | | | |
| Other _____ | | | | | | |

| HOSPITALIZATIONS AND SERIOUS ILLNESS (Including Surgeries): | | | | | | |
|---|---|---|---|---|---|---|
| **Cause/Disease** | **Date:** | **Hospital:** | | **Outcome:** | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

| **Last Tetanus Shot** | **Last Pneumonia Shot** | **Any Transfusions?** |
|---|---|---|
| Date: | Date: | Date if yes: |

| **HEALTH HABITS:** | **Check if Used:** | **How much and How Long?** |
|---|---|---|
| Tobacco | | |
| Drugs | | |
| Alcohol | | |
| Caffeine | | |

| **Your Occupation:** | **Stress:** | **Hazardous Materials:** | **Heavy Lifting:** |
|---|---|---|---|
| **Check Exposure To:** | | | |

| **Medications:** | **Allergies to Medications:** |
|---|---|
| | |
| | |
| | |

***I certify that the above information is correct to the best of my knowledge. I will not hold my doctor and any member of the staff responsible for any errors or omissions that I may have made in the completion of this form.***

_____ _____

***Signature of Patient or Legal Guardian*** ***Date***

_____ _____

***Print Patient's Name*** ***Print Name of Legal Guardian, if applicable***