



P.O. Box 191 Princess Anne, MD 21853
410.651.9852 410-651-1279 (FAX)

TLCCS OFFICE POLICY

Dear Patient~

Welcome. To help acquaint you with the office, we have prepared a few words about our policies and fee schedule. Please read this and sign below indicating that you understand the guidelines.

Your appointment

Your appointment is set aside for you and your provider. Please understand that we allow a significant amount of time for each patient and a *missed appointment is lost time* which could have gone to another sick patient. Please notify us to cancel a day ahead. If you miss 2 appointments, we will accept you on a walk-in basis. TLCCS, Inc. will endeavor to contact patients 48 hours in advance to confirm your appointment. Reporting patient concerns: Three Lower Counties Community Services encourages you to bring any concerns or complaints about safety and quality of care to our attention. To contact us, call the TLCCS office telephone number where you receive care and ask to speak to the Administrator or designee.

FINANCIAL POLICY DISCLOSURE/PAYMENT AGREEMENT

GUARANTEE OF PAYMENT: Three Lower Counties Community Services Inc. will submit billing for medical services to your insurance company on file; however, the amount remains the responsibility of the guarantor/patient.

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION: Patient hereby authorizes Three Lower Counties Community Services Inc. to release my diagnosis and other medical information to the third parties in order to secure payment for services rendered by the TLCCS, Inc. provider and other healthcare providers.

Current Fee Schedule

- Three Lower Counties Community Services Inc. has a set fee schedule for evaluations and management of patients as well as procedures.
- Patients are required to present their insurance card during all visits, if they have one. If you have a change of address or insurance, please notify us.
- If uninsured, a minimal payment is expected at the time of the visit, according to the TLC Self-Pay Declaration Policy.

Positive Account Balances and Evidence of Income Proof for Self-Pay Patients

The Patient Service Representative (PSR) will go over your balance privately. It is your obligation to provide evidence of income within 15 days if you self-pay. If the undersigned fail(s) to present evidence of income within 15 days after applying for the sliding scale, the undersigned will be paying the full price for the previous and subsequent visits. We reserve the right to collect unpaid balances.

I certify that I understand the contents of the TLCCS Policy and all information given is accurate and correct. A photocopy of this agreement will be valid.

Patient or Guardian (if a minor) Signature

Date

Witness Signature

Date



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Dear

Thank you for scheduling your new appointment with Three Lower Counties Community Services Inc. We look forward to a long and rewarding relationship with you. If you have any questions or concerns, please bring them to your appointment. We will be happy to discuss them with you.

A Registration Form and our Office Policy/Consent to Treat Form are attached. Please fill these out and bring them with you. We will need this information for your record. For your initial appointment, we ask that you come in twenty minutes early so that we may process your information. For your protection, we ask that you bring a photo identification with you.

Thank you for your cooperation, and again, we welcome you to TLCCS.

Sincerely,

Linda Riggleman, Administrator
Medical Department
Princess Anne - 410-651-1000
Salisbury - 410-219-1100)

Marianne Asplen, Administrator
Mental Health Department
Princess Anne – 410-651-1000
Salisbury – 410-651-1100

Catherine Borum, Administrator
Dental Department
Princess Anne – 410-651-1000

Sue Gray, Administrator
Ob/Gyn Department
Princes Anne – 410-651-1000
Salisbury – 410-219-1100
Phillip Morris Drive – 410-546-2424

Your Appointment Date and Time: at



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If label unavailable, Patient/Guardian: Please complete information below:

Patient Name _____

Patient Date of Birth _____

Authorization and Consent to Treatment

1. I consent to and authorize the administration of all routine ambulatory clinical care, the performance of all examinations, diagnostic procedures and treatment, including medical, surgical or X-ray procedures or treatment, which in the judgment of my attending physician/dentist/clinician, may be necessary or desirable for my medical care.

a. I understand that in the event my attending physician/dentist/clinician believes treatment involving material risks to me or my health is indicated, he will explain those risks to me before such treatment is administered.

b. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as to the result of treatments or examination in the clinic.

c. I understand that Three Lower Counties Community Services Inc. (TLCCS) participates in the training of medical students, nurses, and allied health students who may observe or participate in patient care while under the supervision of a credentialed provider.

2. I consent to the release of protected health information (PHI) for the purpose of carrying out treatment, payment, and health care operations. However, I have the right to request TLCCS to restrict the use or disclosure of protected health information (PHI) for treatment, payment and health care operations (TPO). Three Lower Counties Community Services Inc. is not required to agree to such restrictions.

3. I acknowledge that Three Lower Counties Community Services Inc. has provided me a copy of the Notice of Privacy Practice (NPP) on or after April 14, 2003, and has made me aware that I have the right to review such notice to giving consent. TLCCS reserves the right to change the terms of the NPP as necessary. The NPP may be revised at the direction of the Privacy Officer.

Acknowledgement of NPP and TLCCS Patients Rights Notice: _____ (Please initial)

4. I also understand my rights and obligations in the physician-patient relationship I establish with TLC providers. I will follow up advice given by my provider and come for appointments as scheduled. If I decide to cancel my appointment, I will call TLC or inform them in writing.

PLEASE CALL TO CANCEL APPOINTMENTS

5. This form has been fully explained to me and I certify that I understand its contents.

Provider or Patient Service Rep. Signature

Patient or Legal Guardian Signature

Date

Provider or Patient Service Rep. name (printed)

Patient or Legal Guardian name (printed)

Date

Adult/Peds/OB/Dental/MH

My docs/Forms/Authorization of Treatment Eng Spn

1/29/07



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Si la etiqueta no esta disponible, Paciente/Guardián: Por favor complete la información abajo:

Nombre del paciente: _____

Fecha de Nacimiento del Paciente: _____

Autorización y Consentimiento a Tratamiento

1. Yo doy mi consentimiento y autorizo a la administración por todo el cuidado clínico ambulatorio de rutina médica, el desempeño de todos los exámenes, procedimientos diagnósticos y tratamiento, incluyendo procedimientos médicos, quirúrgicos o de rayos-x (radiografías) o de tratamiento, cuál en el juicio de mi médico/dentista/clínico, puede ser necesario o deseable para mi cuidado médico.
 - a. Entiendo que si en caso que mi médico/dentista/clínico cree que un tratamiento ponga en riesgo a mi salud, él me explicará esos riesgos antes de administrar el tratamiento.
 - b. Estoy enterado que la práctica de la medicina y la cirugía no son ciencias exactas, y yo reconozco que no se me han hecho garantías sobre los resultados de tratamientos o de exámenes hechos por la clínica.
 - c. Yo entiendo que Three Lower Counties Community Services Inc. (TLCCS) participa en el entrenamiento de estudiantes médicos, enfermeras, y estudiantes de salud aliados los cuales tal vez pasen a observar o participen en el cuidado del paciente bajo la supervisión de un proveedor certificado.

2. Yo doy mi consentimiento para que mi información medica protegida (PHI) sea disponible para el propósito de seguir con tratamientos, pagos, y funciones del cuidado medico. Sin embargo, yo tengo el derecho a solicitar de TLCCS una restricción sobre el uso y la revelación de mi información medica protegida (PHI) para tratamientos, pagos, y funciones del cuidado medico (TPO). Three Lower Counties Community Services Inc. no esta en la obligación a cumplir con tales restricciones.

3. Yo estoy acuerdo de que Three Lower Counties Community Services Inc. me proveyó una copia del Aviso Sobre Practicas Relacionadas con la Privacidad (NPP) en o después del 14 de abril del 2003, y me han informado de que yo tengo el derecho de revisar el aviso antes de dar mi consentimiento. TLCCS tiene el derecho de modificar el contenido del NPP cuan sea necesario. El NPP puede ser modificado bajo la dirección del oficial de la privacidad.

Acuerdo de NPP y la notification de los derechos de los pacientes de TLCCS _____ (Por favor ponga sus iniciales)

4. Yo también entiendo mis derechos y obligaciones en la relación entre medico y paciente que yo estableceré con los proveedores de TLC. Yo seguiré los consejos que me de mi proveedor y llegare a las citas que me den. Si yo decido cancelar mi cita llamare a TLC, o les informare por forma escrita.

POR FAVOR LLAME SI TIENE QUE CANCELAR SUS CITAS

5. Esta forma ha sido completamente explicada y certifico que entiendo sus contenidos.

Provider or Patient Service Rep. Signature

Firma del Paciente o Guardián Autorizado

Fecha

Provider or Patient Service Rep. Name (printed)

Nombre del Paciente o Guardián Autorizado

Fecha

Adult/Peds/OB/Dental/MH

NT My docs/Forms/Authorization of Treatment Eng Spn

1/29/07



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PATIENT INFORMATION FORM

Date: _____

PATIENT INFORMATION

Name _____
 Address _____
 City _____
 State _____ Zip _____
 Social Security # _____
 Date of Birth _____
 Homeless _____ Migrant worker _____ Seasonal farm worker _____
 Language best served _____
 Usual provider _____

CHART # _____
 Home Phone _____
 Work Phone _____
 Cell Phone _____
 Pager _____
 Race _____
 Sex _____ Marital Status _____
 Email Address: _____
 Disaster Identifier _____

Are you a patient in any other department at TLC? (Please circle all that apply)

Pediatrics Adult Medicine Ob/Gyn Dental Mental Health

EMPLOYMENT INFORMATION

Employer _____ Phone _____
 Address _____
 City _____ State _____ Zip _____

PARENT / GUARDIAN CONTACT

Parent/Guardian _____ Home Phone _____
 Address _____ Work Phone _____
 City _____ Cell Phone _____
 State _____ Zip _____ Pager _____

Person to contact in case of an emergency _____
 Relationship _____ Phone _____

INSURANCE INFORMATION

Medical Dental Mental Health

Insurance Co. _____ City _____
 Street Address _____ State/Zip _____
 Subscriber Name _____ Subscriber Employer _____
 Cert/Mem ID # _____ Subscriber D.O.B. _____
 Group Number _____ Subscriber SSN _____
 Subscriber Relationship to Patient _____ Subscriber Phone _____
 Effective date _____ Expiration date _____

Do you have additional Insurance? (Circle One) YES NO

If Yes, please complete the following:

Insurance Co. _____ City _____
 Street Address _____ State/Zip _____
 Subscriber Name _____ Subscriber Employer _____
 Cert/Mem ID # _____ Subscriber D.O.B. _____
 Group Number _____ Subscriber SSN _____
 Subscriber Relationship to Patient _____ Subscriber Phone _____



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Authorization for Release of Medical Records

Patient's name _____ DOB _____ SS# _____

Address _____ Phone _____

1. Persons or group of persons authorized to **use/disclose** this information and purpose:

<input type="checkbox"/> Three Lower Counties Community Services, Inc.	Purpose:	<input type="checkbox"/> My personal health records
<input type="checkbox"/> _____ Name of physician/provider		<input type="checkbox"/> Transferring to another provider
_____		<input type="checkbox"/> Sharing information with another provider
Street _____ State _____ Zip _____		<input type="checkbox"/> Other _____

2. Persons or group of persons authorized to **receive** this information:

<input type="checkbox"/> Three Lower Counties Community Services, Inc.	<input type="checkbox"/> Me
<input type="checkbox"/> _____ Name	
Street _____ State _____ Zip _____	Telephone _____ Fax _____

3. Description of information to be used or disclosed: *(Please mark box with an X)*

<input type="checkbox"/> Copies by mail	<input type="checkbox"/> Records of health care	<input type="checkbox"/> Mental Health records	<input type="checkbox"/> HIV information	<input type="checkbox"/> Shot records
<input type="checkbox"/> Dental records	<input type="checkbox"/> X-ray & other images	<input type="checkbox"/> All		

4. ***This section must be completed if request for disclosure is made by someone other than the above-named patient:***

<p>Purpose for disclosure:</p> <p>I understand that the person I am authorizing to use/disclose my protected health information may receive compensation for doing so. _____ (patient initials)</p> <p>I understand that I may refuse to sign this authorization and that if I do, it will not affect my ability to obtain treatment or payment or eligibility for benefits and that I may inspect or copy any information used or disclosed under this authorization. _____ (patient initials)</p>

5. I understand that if the party receiving this information is not a health care provider or health plan subject to the federal privacy regulations that the information described above may be redisclosed and no longer protected by the privacy regulations.
_____ (patient's initials)

6. I understand that I may revoke this authorization in writing at any time except to the extent that action on this authorization has not already occurred.

7. This authorization becomes effective _____ and will expire on _____.
Date Date

_____	_____	_____
<i>Patient (or Representative) Signature</i>	<i>Relationship to Patient</i>	<i>Date</i>
_____	_____	
<i>Witness Signature</i>	<i>Date</i>	

OUR PLEDGE:

We understand that health information about you and the care you receive is personal. We are committed to protecting your personal health information. When you receive treatment and other health care services from us, we create a record of the services that you received. We need this record to provide you with quality care and to comply with legal requirements. This notice applies to all of our records about your care, whether made by our health care professionals or others working in this office, and it tells you about the ways in which we may use and disclose your personal health information. This notice also describes your rights with respect to the health information that we keep about you and the obligations that we have when we use and disclose your health information.

We are required by law to:

1. Make sure that health information that identifies you is kept private in accordance with relevant law.
2. Give you this notice of our legal duties and privacy practices with respect to your personal health information.
3. Follow the terms of the notice that is currently in effect for all of your personal health information.

HOW TO COMPLAIN ABOUT OUR PRIVACY PRACTICES

If you think that we may have violated your privacy rights or you disagree with a decision we made about access to your personal health information, you may file a complaint with the person listed below. You also may send a written complaint to the Regional Manager, Office for Civil Rights, U.S. Department of Health and Human Services, 150 S. Independence Mall, Suite 372, Philadelphia, PA 19106. We will take no retaliatory action against you if you file a complaint against our privacy practices.

THE PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT OUR PRIVACY PRACTICES

If you have any questions about this Notice or any complaints about our privacy practices, or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, please contact:

Privacy Officer
TLC Community Services
P.O. Box 191
Princess Anne, MD 21853
410-651-9852

This Notice went into effect April 14, 2003



NOTICE OF PRIVACY PRACTICES

www.tlccs.org

NOTICE OF PRIVACY

THIS NOTICE DESCRIBES A SUMMARY OF HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED & DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

We may use and disclose your personal health information for these purposes:

For treatment: We may use and disclose health information about you to doctors, nurses, technicians, medical students, and others who are involved in your care.

For payment: We may use and disclose health information about you to bill and collect payment for the treatment and services provided to you. We may also provide this information to your health insurance plan to process claims or get pre-approval for coverage of treatment.

For health care operations: We may use and disclose health information about you to operate this clinic, to assist other providers involved in your care, to ensure quality care, and to evaluate the performance of our staff in caring for you.

Appointment reminders & health-related services: We may use and disclose health information about you to provide appointment reminders, or give you information about treatment alternatives or other health-related services that we offer.

Disclosures to family, friends, or others: We may release health information about you to a friend or family member who is involved in your health care, or to the person who helps pay for your care.

Research: Under certain circumstances, we may use and disclose health information about you for research purposes, which would be subject to a special approval process.

For purposes of organ donation : We may notify organ procurement organizations to assist them in organ, eye, or tissue donation and transplants.

As required by law: We will disclose health information about you when required to do so by federal, state, or local law.

To avert a serious threat to health or safety: We may use and disclose health information about you if necessary to prevent serious threat to your health and safety, or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

Military & Veterans: If you are a member of the armed forces or separated/discharged from military services, we may use and disclose health information about you as required by military command authorities or the Department of Veterans Affairs, as may be applicable.

Workers' Compensation: We may use and disclose health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Activities: We may release health information about you to prevent or control disease, injury or disability and to report: births and deaths, child abuse or neglect, medication reactions or problems, product recalls, and to notify of exposure to disease. We also may notify the appropriate authority if we believe a patient has been the victim of abuse, neglect or domestic violence when required by law.

Health Oversight Activities: We may provide information to assist the government when conducting an investigation or inspection of a health care provider or organization.

Lawsuits and Disputes: We may use and disclose health information about you in response to a court or administrative order, a subpoena, discovery request, or other lawful process, but only if efforts have been made to tell you about the request or obtain an order protecting the information requested.

Law enforcement: We may release health information about you if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, or summons; or to identify or locate a suspect, fugitive, material witness or missing person; or under certain circumstances, about the victim of a crime or criminal conduct at the clinic.

For specific government functions: We may use and disclose health information about you to authorized federal officials for intelligence and other legal national security activities; or provide protection to the President or foreign heads of state. We may also release health information about you to a coroner or health examiner.

Inmates: Only if a release of health information would be necessary for the institution to provide health care, to protect your health and safety, or for the safety and security of the correctional institution.

Other: Other uses and disclosures of your personal health information would require your prior written authorization. You can revoke this written authorization at any time in writing. We would not be able to take back any uses we had already made with your authorization prior to revoking it.

YOUR RIGHTS

Right to inspect & copy: You can inspect and copy your personal health information in your records, upon a written request. In certain very limited circumstances, your request may be denied; you can then request that the denial be reviewed. We will comply with the outcome of the review.

Right to amend: If you feel information maintained about you is incorrect or incomplete, you can request an amendment to your record in writing, and it must contain a reason to support your request for an amendment. We may deny your request if it is not in writing or legible or if it: was not created by us, is not part of the health information kept by or for the health center, is not part of the information which you would be permitted to inspect and copy, or if the information is accurate and complete.

Right to receive an accounting of disclosures: Any accounting will not include uses or disclosures that you have already consented to, such as those made for treatment or with a written authorization, those that went to a family member/friend involved in your care when you gave us permission to, or to law enforcement officials. The request needs to be in writing.

Right to request restrictions: You have the right to ask that we limit how we use and disclose your information, except disclosures we are legally required to make. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for your care, such as a family member. We are not required to agree to your request if it is not feasible for us to comply or if we believe that it will negatively impact our ability to care for you. If we agree, however, we will comply with your request except in emergency situations. Requests must be in writing.

Right to receive confidential communications: You can request in writing that we communicate with you about health matters in a certain way. For example, you can ask that we contact you at work only, or by mail to a specified address. We will accommodate all reasonable requests and we will not ask you the reason for your request.

Right to a paper copy of this Notice: You have the right to receive a copy of this Notice at any time. Please request it from our Privacy Officer in writing.

In an emergency situation, people may not be able to get to their medical records. The **Keep It With You (KIWY) Personal Medical Information Form** is intended to be a voluntary and temporary record that lists medical care and other health information for people who need care during disasters and similar situations. It is important for health care workers to have a simple and reliable way to learn information about past and new health concerns for people receiving help.

Directions: Please fill in as much information as you can on the form. It is okay if you don't fill out every space. You might want to use a pencil if some information will change such as your address. Some information will be filled out by a health care worker, like "Active Diagnoses" and "Health Care Encounters" information. If you have an Immunization Card listing the shots you have had recently, please staple it to this form. You can store this form in a plastic bag for safe keeping.

For Health Care Workers: The KIWY form is not intended to replace hardcopy or electronic medical records, but is an interim communication tool to assist people as they navigate a potentially complex system of temporary support, housing, and clinical services. Clinicians are encouraged to adapt this format and content as necessary. It is suggested that care providers **photocopy** the document after an individual receives care, in order to maintain a record of their treatment. The original form is intended to **remain with the individual** during the time they are displaced.

HOW TO CONTACT US

Three Lower Counties Community Services Inc.

12137 Elm Street
Princess Anne, MD 21853

Dental
410-651-5151

12145 Elm Street
Princess Anne, MD 21853

Internal Medicine
Ob/Gyn
Pediatrics
410-651-1000

Mental Health
410-651-2204

1104 Healthway Drive
Salisbury, MD 21804

Internal Medicine
Ob/Gyn
Pediatrics
Mental Health
410-219-1100

305 Tenth Street, Suite 104
Pocomoke City, MD 21851

Internal Medicine
Pediatrics
410-957-1852

www.tlccs.org



KEEP IT WITH YOU

PERSONAL MEDICAL
INFORMATION FORM

FOR PEOPLE WHO NEED CARE
DURING DISASTERS

*This pamphlet can be kept
in a plastic bag for
safe keeping in case of
An emergency*

www.tlccs.org

HEALTHCARE ENCOUNTERS

Date _____ Location _____
Symptoms/Diagnoses _____

Tests/Results _____
Treatment/Follow-up Needs _____

Date _____ Location _____
Symptoms/Diagnoses _____

Tests/Results _____
Treatment/Follow-up Needs _____

Date _____ Location _____
Symptoms/Diagnoses _____

Tests/Results _____
Treatment/Follow-up Needs _____

Date _____ Location _____
Symptoms/Diagnoses _____

Tests/Results _____
Treatment/Follow-up Needs _____

Date _____ Location _____
Symptoms/Diagnoses _____

Tests/Results _____
Treatment/Follow-up Needs _____

Notes: _____

PERSONAL INFORMATION

Name _____
Date of Birth ____/____/____ Male__ Female__
E-mail address _____
Home address _____

City _____
State _____ Zip _____
Phone Number _____

Temporary Address _____

City _____
State _____ ZIP _____
Phone Number _____

Previous evacuee center location(s):
Facility _____ City _____
Facility _____ City _____
Facility _____ City _____
Facility _____ City _____

ID Number/Case Number (if available): _____

Parent/Guardian/Other Support Person:
Name _____
Phone # or other contact info _____

Relationship _____

ACTIVE DIAGNOSES:

ALERTS:

DOCTOR OR CLINIC BEFORE EVALUATION (if known):

Name _____
City _____ State _____

ALLERGIES:

ACTIVE MEDICATIONS

Name of pharmacy chain (if known) _____

Medication _____
Instructions _____
Medication _____
Instructions _____
Medication _____
Instructions _____
Medication _____
Instructions _____
Medication _____
Instructions _____
Medication _____
Instructions _____
Medication _____
Instructions _____
Medication _____
Instructions _____
Medication _____
Instructions _____
Medication _____
Instructions _____

Immunizations received since Evacuation _____

Attach immunization card if you have one.