



Patient Information

(Please print)

Full Legal Name: Last First Middle Preferred Name: Sex: Male Female Date of Birth: Month/Day/Complete Year SS#: Ethnicity: Hispanic/Latino Non-Hispanic/Non-Latino Refuse/Decline Primary Care Physician: Preferred Pharmacy Name: Phone Number: Marital Status: Single Married Divorced Widowed Life Partner Legally Separated Race: Caucasian (white) American Indian African American (black) Hispanic Biracial Asian Oriental Other Unknown Home Address: City: State: Zip: Mail to Address: City: State: Zip: County: Home Phone: Cell Phone: Preferred language: E-mail: Veteran: Yes No Unknown Religion:

Guarantor Information (If guarantor is Self, skip to Emergency Contact)

Parent/guardian presenting minor child for treatment will be listed as the guarantor. If 18 or older, patient will be listed as guarantor and does not have to complete this section. The guarantor will be responsible for any balance due.

Name: Last First Middle Patient relation to Guarantor: Home Phone: Cell Phone: Date of Birth: SS#: City: State: Zip: Country: Home Address: City: State: Zip: Country: Mail to Address (if different): City: State: Zip: Country:

Emergency Contact (Pediatric Patients please list someone other than parent(s)/guardian)

Primary Contact Name: Home Phone: Cell Phone: Patient Relation to Emergency Contact Secondary Contact Name: Home Phone: Cell Phone: Patient Relation to Emergency Contact

Employment

Patient Employer: Work Phone: Ext: Address: City: State: Zip: Employment Status: Full-Time Part-Time Self Employed Active Military Student Full Time Student Part-Time Retired Date Disabled Not Employed Unknown

(Pediatric Patients Only) Parent/Guardian & Immediate Family Information

Mother (If the address, phone numbers and employer information is the same as guarantor, please indicate same.)

Full Name: Last First Middle Nickname: Date of Birth: Month/Day/Complete Year SS#: Home Address: City: State: Zip: Home Phone: Cell Phone: Employer: Work Phone: Ext:

Father (If the address, phone numbers and employer information is the same as guarantor, please indicate same.)

Full Name: Last First Middle Nickname: Date of Birth: Month/Day/Complete Year SS#: Home Address: City: State: Zip: Home Phone: Cell Phone: Employer: Work Phone: Ext:

Patient Name _____

DOB _____

(Pediatric Patients Only) Brothers, Sisters & Other Family Members

Full Name	M or F	Date of Birth	Relationship	Lives with child	
				Yes	No

Check here if no insurance. And, skip to Authorization (below).

Accident Information

Is visit the result of an accident? (Examples: auto accident, workers compensation, etc.)

Yes No

Type of Accident: _____ Date of Accident: _____ County of Accident: _____

Primary Insurance Information

Subscriber: This is the person who carries the insurance. If Subscriber is the Patient, skip to Insurance Co Name field.

Subscriber's Name on card: _____ Date of Birth: _____
Month / Day / Complete Year

Patient Relationship to Subscriber: _____ Sex: Male Female

If address and phone number is same as patient, please indicate same.

Address: _____ SS#: _____

City, State, Zip: _____ Home Phone: _____

Employer: _____ Work Phone: _____ Ext. _____

Insurance Co. Name: _____ Phone: _____

Policy/Cert #: _____ Group No: _____ Effective Date: _____

Subscriber Status: Full-Time Part-Time Self Employed Active Military Student Full Time
 Student Part-Time Retired Date _____ Disabled Not Employed

Secondary Insurance Information

SUBSCRIBER: This is the person who carries the insurance. If Subscriber is the Patient, skip to Insurance Co Name field.

Subscriber's Name on card: _____ Date of Birth: _____
Month / Day / Complete Year

Patient Relationship to Subscriber: _____ Sex: Male Female

If address and phone number is same as patient, please indicate same.

Address: _____ SS#: _____

City, State, Zip: _____ Home Phone: _____

Employer: _____ Work Phone: _____ Ext. _____

Insurance Co. Name: _____ Phone: _____

Policy/Cert #: _____ Group No: _____ Effective Date: _____

Subscriber Status: Full-Time Part-Time Self Employed Active Military Student Full Time
 Student Part-Time Retired Date _____ Disabled Not Employed

Authorization

I authorize medical evaluation & treatment, and release of information for insurance/medical purposes concerning my illness and treatment. I hereby authorize payment from my insurance company to the Greenville Health System for services rendered. I will be responsible for any amount not covered by my insurance.

Signature of Patient/Guardian/Guarantor: _____ Date: _____

Carolina Pediatrics Policies

Emergency Calls (Day or Night)

- Call 911 (Emergency Medical Services) for any life-threatening emergencies for which your child might require resuscitation (e.g., your child is not breathing or is having severe difficulty breathing, is severely choking, has been knocked unconscious, or is having a seizure).
- Please state clearly "This is an emergency." Do not let the answering service or office staff put you on hold. Reserve this for true emergencies only.
- For poisonings, call the Poison Control Center at 1-800-222-1222.

Calls about sick children between 9a.m.-7p.m. We see children by appointment only during our office hours:

Weekdays 9:00 am to 7:00 pm
Saturday 9:00 am to 12:00 pm.

- Try to make appointments for sick children during the early morning office hours.
- All medical calls are forwarded to a nurse who has been trained to determine which patients need to be seen by the physician and how to provide home care for children.
- Our receptionist will forward your message and child's chart to our nurse, who will call you back. While waiting for a call back, try to keep your line open. If your call isn't returned within 2 hours, please call again. Keep in mind that Mondays and Fridays are typically busy, so please be patient while waiting for your return call.
- If our nurse can't help you, she will schedule an appointment or a physician will call you back.

Well-Child Questions

We are happy to provide you with the health information that you need. However, please place calls about behavior issues or other well-child issues during weekday office hours.

Prescriptions and Refills

We provide prescriptions and refills only during office hours. If by non-appointment, there is a \$25 fee for new prescriptions and \$15 for refills. We need your child's chart to obtain pertinent medical information. Always have the phone number of your pharmacy available when you call the office.

After-Hours Calls: Night time, Weekends, and Holidays

After office hours calls should be made only for emergent situations that cannot wait until morning. Your calls will be received by our answering service and transferred to a nurse. The nurse will usually return your call within 30 minutes. **If you do not receive a call back within 30 minutes call again.**

PLEASE HAVE THE FOLLOWING INFORMATION AVAILABLE WHEN YOU CALL ABOUT A SICK CHILD:

- Your child's main symptoms
- Any chronic disease of health problem your child has
- Your child's temperature; we need a rectal temperature if child is younger than 2 years
- Your child's approximate weight
- The names/dosages of any medicines your child is taking
- Your pharmacy's telephone number
- Your questions (it is a good idea to have them written down).

Always have a pen and paper to take down instructions and have your child nearby in case you need to check something about his or her condition.

Financial Policies

- Payment is due at time of service. The person who brings the child is responsible for paying the co-pay and/or balance.
- Returned checks will incur a \$25.00 service fee.
- Delinquent accounts will be forwarded to a Collection agency. Your child/children will be expelled from the practice if your account is forwarded to a collection agency which you will receive the final notice by certified mail, unless we have the incorrect address and/or contact information.
- You are responsible for knowing your insurance benefits and requirements.
- You need to determine if your policy covers well-visits and immunizations. The benefit can change with your child's age and result in a large unpaid balance that will be your responsibility. If we know before the shots are administered that your insurance does not cover immunizations, we can administer vaccines that the state provides to us and it will only cost you the administration fee.

Appointment Policies

- If you are running late please call the office as soon as you can, we may be able to rearrange the schedule to keep everyone's wait to a minimum.
- If you are 15 minutes late for a well visit, we must reschedule it.
- If you are 15 minutes late for a sick visit, we will give you the next available appointment.
- We need as much advance notice of appointment cancellation as possible, ideally 24 hours.
- If you do not show for 3 consecutive appointments, the patient and siblings will be dismissed from the practice.
- There is a \$25 fee for "no-show" appointments and/or less than 24 hour notice cancellations.

Address Changes and Insurance Changes

- Please inform us before moving of your new address. If you fail to inform us it may result in delinquent bills or a collections account.
- Insurance changes are very important to update immediately. Failure to do so can result in our inability to file claims for you. All insurance companies have deadlines for filing claims (90 days-1 year). If we fail to make a deadline as a result of inaccurate insurance information, you are responsible for the balance.

I have read and understand the policies outlined in this document. Acknowledge by signing below. _____

Initials

Patient's Name: _____

Date of Birth: _____

I have received Carolina Pediatrics' Notice of Privacy Practices. I understand how medical information may be used or released. Carolina Pediatrics is required by federal law to obtain your acknowledgement that you have received this notice. Acknowledge by signing below.

Signature of Responsible Party/Relationship to Patient

Date: _____

IMPORTANT PHONE NUMBERS

CAROLINA PEDIATRICS 454-2670
POISON CONTROL 1-800-221-1222



Authorization for Release of Medical Information

One Per Request

Patient Full Name (Print) _____ MRN (office use) _____ DOB _____

is requesting that the Greenville Health System release health information

(check one) [] To or obtain [] From the person/company/agency/facility listed below.

Name, Position, or Department: _____

Name of Organization: _____

Address of Organization: _____

Phone number of Organization: _____

The information to be disclosed relates to service dates beginning _____ and ending _____

- Entire Medical Record, Demographic Information, History & Physical, Medical/Surgical History, Physician Office Visits, Medication List, Immunizations, Test Results (lab, X-ray, etc.), Other Assessments, Discharge Summary, Physical Therapy Notes, Occupational Health Record, Other: (specify)

The purpose of the disclosure: ("Request of the Individual" is sufficient for patient-initiated releases)

- Request of Individual, Referral to Specialist, Continuing Care, Change of Doctor, Insurance, Workers' Comp, Legal Investigation, Other: (specify)

Conditions and Notifications:

This authorization for release of information expires 12 months from the date of patient's signature. You may revoke this authorization at any time by writing to the Office Supervisor/Manager. However, such notification will not affect any actions taken in reliance on this authorization prior to the time of receipt of the revocation. You may inspect or request a copy of the health information to be used or disclosed, consistent with federal law. This authorization is being given to the GHS University Medical Group, to GHS, and each practice and entity affiliated with it including GHS Partners in Health.

Note: There may be a processing fee charged to the patient to cover labor, copying, and supplies used to reproduce medical records.

Signatures:

I hereby authorize the use or disclosure of the personal health information as described above. I understand that I may refuse to sign this authorization, that this authorization is voluntary, and that my health care and the payment for my health care will not be affected if I do not sign this form. I also understand that if the individual or organization authorized to receive the information is not a health plan or health provider, the released information may no longer be protected by federal privacy regulations and, therefore, may be subject to re-disclosure.

Signature of Patient/Personal Representative: _____ Date: _____

Print Name of Personal Representative: _____

Relationship of Representative to Patient: _____

Released by: _____ Date: _____ (Department Representative Name)

Additional Form Required for Each Provider



AUTHORIZATION FOR DISCLOSURE OF MEDICAL INFORMATION

THE INFORMATION PROVIDED IN THIS FORM WILL BE RELIED UPON BY ALL HEALTH CARE PROVIDERS OF GREENVILLE HEALTH SYSTEM UNLESS REVOKED OR MODIFIED BY THE PATIENT IN WRITING.

Patient Name (PRINT) _____

(For Office Use Only)

DOB _____

MRN _____

Authorization for Disclosure of Medical Information: The privacy of your medical information is important. We will discuss your medical condition with person(s) you designate.

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHOM? (Check and complete one)

The following family members or other individuals may receive information regarding my medical condition:
Print first and last name(s) _____

OR

Any family member or other individual inquiring about my medical condition may receive information from my provider, EXCEPT the following individuals: *Print first and last name(s)* _____

You may revoke/cancel or modify/change the above designation, but the revocation or modification must be in writing.

NOTE: This designation does not give the above named individuals the right to make health care decisions for you. If at any time you are unable to consent to care or treatment, we will follow the procedure set forth in the South Carolina Adult Health Care Consent Act.

Confidential Communication: Please provide phone number(s) where we can reach you:

Home: _____ Work: _____ Cell Phone: _____ Other _____

Messages: A request for return calls may be left on the following answering machine or voice mail: *(Check all that apply)*

Home Work Cell Phone I do not authorize

I authorize my medical information to be left on the following answering machine or voice mail: *(Check all that apply)*

Home Work Cell Phone I do not authorize

If we are unable to reach you or leave a message at the above phone number(s), please indicate with whom we may leave a message for you to call our facility.

Name _____ Phone Number _____

Name _____ Phone Number _____

Note: An automated appointment reminder system may call the number listed in our data base.

Signature: I hereby authorize the disclosure of my medical condition and information as described above.

Patient/Patient's Representative Signature: _____ Date: _____ Time: _____

PRINT Name (if Patient's Representative): _____

Relationship to Patient (if Patient's Representative): _____

GHS Representative: _____ Date: _____ Time: _____

Form Create Date: December 30, 2013



Patient's Name: _____

Patient's Date of Birth: _____

Sex: _____

CONSENT AND AUTHORIZATION - UMG

The following are conditions for services provided by the Greenville Health System (GHS) for the above-named patient :

CONSENT AND AUTHORIZATION FOR ROUTINE TREATMENT: I consent to and authorize GHS and my health care providers to provide or order routine health care services, including diagnostic and laboratory procedures that in the judgment of my provider(s), are necessary. Unless otherwise discussed with me, I authorize GHS to dispose of specimens, tissues, medical devices, or implants removed from my body during my treatment. Diagnostic/laboratory procedures that may be ordered could include testing for HIV, Hepatitis, and other diseases categorized as sexually transmissible diseases. I can tell my provider if I do not want to be tested for any and all of these diseases. If test results are positive, they will be shared with me.

PHYSICIANS: I understand that physicians who are members of the GHS medical staff and who practice in GHS facilities may not be employees or agents of GHS. I understand that GHS is not responsible for any act or omission by a physician who is not an employee or agent of GHS. I understand GHS is a medical teaching institution and that students and residents may be involved in my care with required/appropriate supervision.

ASSIGNMENT OF INSURANCE BENEFITS AND THIRD PARTY CLAIMS: If my account is not paid at the time of my visit, I hereby assign to GHS any and all rights, including proceeds, I may have from the following: TRICARE major medical benefits, PIP (personal injury protection), sick benefits, physician benefits (excluding any benefits payable to physicians who are not employees or agents of GHS), injury benefits, or any other health, accident or welfare benefits of any type or form, whether insured or self funded, proceeds of any liability settlement or judgment being paid by or on behalf of a third party, or any other benefits due from the insurance policy. I also assign to physician(s) not employed by GHS, any proceeds of the foregoing benefits being paid by or on behalf of a third party or due from any insurance policy for services provided at GHS (such as anesthesiologists, pathologists, and other private physicians). I warrant and represent that any insurance or any plan which I assign is valid insurance and in effect and that I have the right to make this assignment. All amounts collected will be applied to my account. I understand that I am responsible for any charges not covered by insurance, including Medicare, Medicaid, or any other benefits. In the event a claim for payment submitted by GHS to my insurance carrier or plan administrator is denied, I hereby authorize GHS to seek an administrative review of the disputed claim in accordance with the applicable provision(s) of my plan or policy, appeal or file a legal/equitable action. If my plan or policy is provided pursuant to the Federal Employees Health Benefits Act, 5 U.S.C. §8901, et seq., this review process will include, but is not limited to, a review by the Office of Personnel Management. In the event I am a participant/beneficiary of an employee welfare benefit plan governed by the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C §1001 et seq., I designate GHS as my authorized representative and grant to GHS the authority to act on my behalf in pursuing and appealing a benefit determination under the plan, including Medicare and Medicaid. Such authority shall include the right to request and receive a copy and/or summary of the plan description.

FINANCIAL AGREEMENT: I understand that I am obligated to pay my account according to the regular rates and terms of GHS, except for those services provided in accordance with a clinical research trial, which are specifically identified in writing as services for which I am not obligated to pay. I hereby appoint GHS as my representative to collect the claims, endorse the checks, and give full and final receipt for all amounts collected. If the benefits received by GHS exceed the charges on my account, I authorize GHS to apply the over-payment to my other outstanding account(s) with GHS or GHS entities, which include GHS Partners in Health, Inc., Greenville Health Corporation, and/or any other entity that is or becomes a part of GHS. If there is no other outstanding account for which I am responsible, the payment will be posted to the intended account and a refund processed accordingly. I understand that GHS may obtain my credit report for review in collection of this account. In the event that this account is placed with a collection agency or an attorney for collection, I will be responsible for paying all costs of collection, including attorney's fees.

MEDICARE PATIENTS: Should I be eligible for Medicare coverage, I request that payment of authorized Medicare benefits be made to GHS on my behalf. The information given by me is correct, in applying for payment under Title XVIII of the Social Security Act.

CONTACTING PATIENTS: I hereby authorize GHS to contact me through the information provided at the time of registration.

DISCLOSURE/USE OF HEALTH INFORMATION: I understand that uses and disclosures of my personal and health information are described in the GHS Notice of Privacy Practices. These include providing my information to other providers for my continuing care, to an insurance company or other payor (such as Medicare) to process payment for my care, and for GHS health care operations such as medical education, peer review and outcomes analysis activities. I understand that my personal and health information will be made available to providers through the GHS Health Information Exchange as described in the Notice of Privacy Practice. I acknowledge by signing below that I have received a copy of the GHS Notice of Privacy Practices.

PHOTOGRAPHING: I consent to GHS taking photographs for purposes of identification, diagnosis, treatment, education, and research. Photographs that could identify me will be used only for internal medical record identification purposes unless I specifically agree and sign an additional consent document.

CONDITIONS FOR CARE; ALTERATIONS VOID: I understand that the above are conditions for care and treatment at GHS. Any alterations to the content of any of the conditions above are void and will not change the conditions as stated. I understand that by signing this form, or receiving care or treatment at GHS, I agree to the contents of this Consent and Authorization in its "as is" form.

SIGNATURE OF PATIENT/LEGALLY AUTHORIZED REPRESENTATIVE _____

PRINTED NAME AND RELATIONSHIP IF OTHER THAN PATIENT _____

DATE _____ TIME _____

SIGNATURE OF WITNESS _____ DATE _____ TIME _____

SIGNATURE OF WITNESS _____ DATE _____ TIME _____
(SECOND WITNESS FOR TELEPHONE CONSENT OR SIGNATURE WITH "X" OR MARK)

CHART COPY

**Carolina Pediatrics of Greenville
Insurance Coverage Statement**

Carolina Pediatrics of Greenville does not accept new Medicaid patients unless there is a sibling currently an established patient at this practice. As a new patient to Carolina Pediatrics, you must understand that you must maintain private insurance and/or self-pay status for at least one full year before you convert to Medicaid coverage (should that be necessary).

Current Insurance Information On: _____
Patient's Name Date of Birth

Sibling's Name and Date of Birth: _____

Sibling's Name and Date of Birth: _____

Sibling's Name and Date of Birth: _____

Sibling's Name and Date of Birth: _____

Sibling's Name and Date of Birth: _____

I understand Carolina Pediatrics of Greenville Medicaid policy as stated above. My child/ren is/are not Medicaid recipients and they have private insurance or I will self-pay for their care. I also understand that my child/ren, as a new patient, cannot convert to Medicaid for at least first full year of care with this practice.

Parent/Guardian's Name and Signature Date

Primary Insurance Information

Insurance Co: _____
Effective Date: _____
Subscriber's Name: _____
Subscriber's SSN: _____
Subscriber's Date of Birth: _____
Employer: _____

Secondary Insurance Information

Insurance Co: _____
Effective Date: _____
Subscriber's Name: _____
Subscriber's SSN: _____
Subscriber's Date of Birth: _____
Employer: _____



Carolina Pediatrics
of Greenville

200 Patewood Drive
Suite A120
Greenville, SC 29615
(864) 454-2670 P
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ghs.org

Insurance Coverage Statement

Tracey Butcher, MD
Emily Cole, MD
Bronwen Greene, MD
Gretchen Mathias, MD
Hae Kyong Nelson, MD
Debra Schwiars, MD
Nancy Song, MD

Dear Parents and Guardians,

Please thoroughly understand what your health insurance provider covers with regards to Vaccinations and Well Child Check (Physical) visits. Not all insurance providers are the same, and many have limitations or no coverage for Vaccinations and/or routine Well Child Checks. If you are not certain of your coverage, please take the time now to call your insurance provider’s customer service number to verify. Vaccinations given at Well Child Checks can be quite costly. If we file your Vaccinations as covered charges, and your insurance rejects the claim, there is no recourse for you but to pay the balance.

If your child is not covered by any insurance provider (Self-Pay), has limited private insurance coverage (Underinsured), or is on Medicaid, then please inform the receptionist upon each visit. We will be happy to enroll you in the South Carolina Department of Health and Environment Control’s Vaccine Assurance for All Children. This program offers Vaccinations at \$13 per Vaccination for Self-Pay and Underinsured patients. Medicaid covers all Vaccinations through this program. Patients are not eligible for this program unless they meet the Self-Pay, Underinsured, or Medicaid criteria.

If your insurance policy does not cover Well Child Checks, or you have reached a cap for coverage, a 30% discount for the physical and labs is available under the SUN Discount program. A form agreeing to this discount must be completed at the time of service. This discounted rate is active for 3 months. If the balance is not paid in full by that time, all charges will go back to full price.

This letter will be part of your child’s records with us.

Please indicate your child’s health insurance coverage:

Private Insurance Co: _____
Vaccinations Covered? ___ 100% ___ Limited
Well Child Checks Covered? ___

Self-Pay (Eligible for Uninsured Discount)

Medicaid provided by: _____

Child’s Name: _____ Date of Birth: _____

Parent/Guardian Name: _____

Parent/Guardian Signature: _____ Date: _____



Vaccines for Children (VFC) Program Patient Eligibility Screening Record Form

A record of all children 18 years of age or younger who receive immunizations must be kept in the health care provider's office for 3 years or longer depending on state law. The record may be completed by the parent, guardian, individual of record, or by the health care provider. VFC eligibility screening and documentation of eligibility status must take place with each immunization visit to ensure the child's eligibility status has not changed. While verification of responses is not required, it is necessary to retain this or a similar record for each child receiving vaccine. Providers using a similar form (paper-based or electronic) must capture all reporting elements included in this form.

1. Child's Name: _____ 2. Child's Date of Birth: ____/____/____

Last Name
First Name
MI

3. Parent/Guardian/Individual of Record: _____

Last Name
First Name
MI

4. Provider's Name: _____

Last Name
First Name
MI

5. To determine if a child (0 through 18 years of age) is eligible to receive publicly funded vaccine through the VFC or state programs, at each immunization encounter/visit enter the date and mark the appropriate eligibility category. *If Column A-D is marked, the child is eligible for the VFC program. If column E, F or G is marked the child is not eligible for federal VFC vaccine.*

	Eligible for VFC Vaccine				Not eligible for VFC Vaccine		
	A	B	C	D	E	F	G
Date of Immunization visit	Medicaid Enrolled (VFC stock)	No Health Insurance (VFC stock)	American Indian or Alaska Native (VFC stock)	VFC 1Underinsured served by FQHC, RHC or deputized provider (VFC stock)	Has health insurance that covers vaccines (Private stock)	2SC State Underinsured, Served by Non-FQHC/RHC (State stock)	3SC State Insured, Insured Hardship, Vaccine Caps (State stock)

¹Underinsured includes children with health insurance that does not include vaccines or only covers specific vaccine types. Children are only eligible for vaccines that are not covered by insurance. In addition, to receive VFC vaccine, underinsured children must be vaccinated through a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) or under an approved deputized provider. The deputized provider must have a written agreement with an FQHC/RHC and the state/local/territorial immunization program in order to vaccinate underinsured children.

²SC State Vaccine Program Underinsured: These children are underinsured but are not eligible to receive federal vaccine through the VFC program because the provider or facility is not an FQHC/RHC or a deputized provider. However, these children may be served with state vaccine program vaccine to cover these non-VFC eligible children. Only providers enrolled in the SC State Vaccine Program are eligible to serve this population. You must have SC State Vaccine program vaccine stock prior to seeing this patient population.

³SC State Vaccine Program - Insured Hardship and Vaccine Caps: These children are considered insured and are not eligible for vaccines through the VFC program. However, these children may be served state vaccine program vaccine to cover these non-VFC eligible children. Insured Hardship is defined as "Health Insurance deductible is greater than \$250.00 per child or \$500.00 per family (Eligible for state vaccine only if the deductible has not been met and the family cannot afford to pay for vaccine)." Vaccine Caps is defined as "Insured but coverage capped at certain amount and cap has been exceeded." The Human Papillomavirus Vaccine is excluded from the SC State Vaccine Program. Only providers enrolled in the SC State Vaccine Program are eligible to serve this population. You must have SC State Vaccine program vaccine stock prior to seeing this patient population.



Consents/Registration
Greenville Health System

**GREENVILLE HEALTH SYSTEM (GHS) PATIENT
PORTAL ACCESS**

A. Patients 16 years old or older or Emancipated Minors

I desire to participate in the Patient Portal. Email address: _____

Signature of Patient _____ Date/Time _____

I authorize proxy access to my Patient Portal to another person. (if applicable to specific portal)

Name of Proxy: _____ Relationship: _____

Email address: _____ DOB: _____

Signature of Patient: _____ Date/Time _____

B. Patients 12 to 15 years old

My parent/legally authorized representative and I desire to participate in the Patient Portal.

Patient hereby assents to the terms and conditions for participation in the Patient Portal and to allowing a parent (or legally authorized representative) to be granted proxy access.

Patient's email address: _____ DOB: _____

Signature of Patient _____ Date/Time _____

Name of parent/legally authorized representative: _____

Email address: _____ Relationship: _____ DOB: _____

Signature: _____ Date/Time _____

C. Patients under 12 years old

I desire to participate in the Patient Portal for my child/ward.

Name of parent/legally authorized representative: _____ DOB: _____

Email address: _____ Relationship: _____

Signature: _____ Date/Time _____

D. Patients unable to consent/assent

I desire to participate in the Patient Portal for the above named patient who is unable to consent/assent.

Name of Proxy: _____ Relationship to patient: _____

Email address: _____ DOB: _____

Signature: _____ Date/Time _____

Appropriate Documentation has been presented to GHS Staff to indicate that the legally authorized representative has authority to sign for the patient.

GHS Staff Signature: _____ Printed Name: _____ Date/Time: _____

****For new information or updates, please fax to 864-454-2539****



Medications, Allergies and Immunizations

Today's Date _____ Patient Name _____ DOB _____

Please Bring All Medications to Your Visit

Prescription Medications -List all medications you are presently taking

Name and Dose	Prescribed by:	How Often	Date Started
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			

Non-Prescription Medications -List all medications you are presently taking

Name and Dose	How Often	Date Started
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		

Current Pharmacy

Name and Location _____ Phone Number _____
Preferred _____
Other _____



Today's Date _____ Patient Name _____ DOB _____

Allergies - list all allergies or unusual reactions you have to medications, foods, dyes latex and other agents.

Allergy	Reaction
1 _____	_____
2 _____	_____
3 _____	_____
4 _____	_____

List any reactions to bug bites or stings _____

Adult Immunizations - Check the box next to or list all immunizations received including the most recent date received.

	Date Received	Others	Date Received
<input type="checkbox"/> Tetanus	_____	_____	_____
<input type="checkbox"/> Flu	_____	_____	_____
<input type="checkbox"/> Pneumonia	_____	_____	_____
<input type="checkbox"/> HPV	_____	_____	_____
<input type="checkbox"/> Hepatitis B	_____	_____	_____

Screenings - List the most recent date and doctor for the following screenings:

	Date	Doctor/Practice/Facility Name
Complete Medical Physical	_____	_____
Full panel of lab work	_____	_____
Cholesterol (lipid) screening	_____	_____
Chest X-ray	_____	_____
Treadmill Stress Test	_____	_____
Other heart tests	_____	_____
Colonoscopy	_____	_____
Mammogram	_____	_____
Bone Density	_____	_____
	_____	_____
	_____	_____
	_____	_____



Today's Date _____ Patient Name _____ DOB _____

Hospitalization & Surgical History - List all hospital admissions and operations you have had.

Reason for Hospitalization/Surgery	Year
1 _____	_____
2 _____	_____
3 _____	_____
4 _____	_____
5 _____	_____
6 _____	_____
7 _____	_____
8 _____	_____
9 _____	_____
10 _____	_____

Yes No Did you have any problems with anesthesia? If yes, please describe.

Social History

Yes No Do you currently smoke or use other tobacco products? If yes, how many per day? _____

Yes No Have you smoked or used other tobacco products in the past? If yes, how many per day? _____
How many years since you last smoked? _____

Yes No Do you drink caffeinated beverages? If yes, what type, how often, how much? _____

Yes No Do you drink alcohol? If yes, what type, how often, how much? _____

Yes No Do you exercise regularly? If yes, what type? _____
How often and how long? _____

Family Medical History - Check the box next to any medical condition below that has affected any of your immediate family members (parents, brothers, sisters), state your relationship and their age at onset.

	Relationship	Age at onset
<input type="checkbox"/> High Blood Pressure	_____	_____
<input type="checkbox"/> High Cholesterol	_____	_____
<input type="checkbox"/> Heart Disease	_____	_____
<input type="checkbox"/> Stroke	_____	_____
<input type="checkbox"/> Migraines	_____	_____
<input type="checkbox"/> Seizures/Convulsions	_____	_____
<input type="checkbox"/> Diabetes	_____	_____
<input type="checkbox"/> Bleeding/Blood-clotting Disorder	_____	_____
<input type="checkbox"/> Allergies	_____	_____
<input type="checkbox"/> Asthma	_____	_____
<input type="checkbox"/> Thyroid Problems	_____	_____
<input type="checkbox"/> Osteoporosis	_____	_____
<input type="checkbox"/> Psychiatric Disorder/Mental Illness	_____	_____
<input type="checkbox"/> Alzheimer's/Dementia	_____	_____
<input type="checkbox"/> Cancer - type:	_____	_____
<input type="checkbox"/> Other:	_____	_____

Financial Policy

Please read this financial policy carefully. If you have any questions about this policy, any member of our staff will be glad to assist you.

The following are the conditions for services provided to the patient by Greenville Health System, GHS Partners in Health, and the various entities and providers affiliated with them each individually and collectively referred to as Greenville Health System or GHS.

Payment for Service: Each office will inform you of co-pay and deductible amounts at check in or check out. These amounts are due at the time of service. As a courtesy to you, we will file your insurance claims if you provide us with a copy of your current insurance card. We require that you pay your deductible, co-payment, and/or any charges not covered by insurance.

Method of Payment: You may pay your bill with cash, personal check, certain credit cards, or debit card.

Returned Checks: A \$25.00 service charge will be added on all checks returned to us for insufficient funds.

Non-appointment Prescription Refills: A \$15.00 charge per incidence may be added for non-appointment prescription refills.

Non-appointment Prescription: A \$25.00 charge may be billed to you for new prescriptions filled via phone.

Completion of Medical Forms: There may be a charge for completion of forms such as disability, camp physicals, etc.

Copies of Medical Records: There may be a charge for completion of this process; SC Sec. 44-7-325 for Health Care Facilities

- \$.65 per page for the first 30 pages
- \$.50 per page for all other pages
- Clerical fee not to exceed \$25.00
- Plus actual postage

No-show Appointments: A fee of \$25.00 for a follow up visit and \$50.00 for a new patient visit or endoscopy procedure may be charged for all missed appointments not canceled at least 24 hours prior to the appointment time. You will be financially responsible for the fee, as insurance plans do not cover these charges. You may notify our office of any cancellations by calling during normal office hours.

Payment for Services Provided by Certain Providers: If you are having laboratory and/or diagnostic services by providers other than this office or other practices doing business as GHS University Medical Group, you may be billed separately by that service provider. This includes services provided by Greenville Health System.

Collection Policy: Delinquent accounts will be forwarded to a collection agency. We will inform you of your account status on your statement. If you are unable to pay your balance promptly, please call us at 864-454-2000 or 1-888-284-6024 to make payment arrangements. We will attempt to contact you by letter before your account is forwarded.

Questions: We are here to help should you have any questions regarding your statement or insurance.

CAROLINA PEDIATRICS NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND RELEASED AND HOW YOU CAN GET THIS INFORMATION. PLEASE READ IT CAREFULLY.

Carolina Pediatrics makes every effort to keep your health information private. Each time you visit Carolina Pediatrics, a record is made. This health or medical record often includes your symptoms, exams and tests, diagnoses, treatment, and care plan. We need this record to give you high-quality care and to meet legal requirements. This Notice applies to all health records produced at Carolina Pediatrics, including those received from other providers. It outlines how we may use and give out information about you for treatment, payment, or healthcare operations, and other purposes granted or required by law. It also describes your rights to get and control your record, and legal requirements we have on its use and release. The law requires Carolina Pediatrics to do the following: (1) Keep your health record private (2) Describe our legal duties and privacy obligations related to your health information (3) Follow the current Notice of Privacy Practices

We reserve the right to change practices and terms of this Notice and the changes will be effective for the information we already have about you and any information we receive in the future. The Notice will list the start date in the top right-hand corner of the first page. Each time you register at Carolina Pediatrics, you may receive a copy of the notice. We will post it in our facilities and on our Web site (www.ghs.org). You may also call our Privacy Office at 864-455-3711 for a copy.

ROUTINE USES AND DISCLOSURES OF YOUR HEALTH RECORD The following sections describe how we use and release medical information. Each section explains what we mean and gives a few examples. (Note: These examples are not all-inclusive.)

Treatment. We use medical information about you to provide, coordinate, and manage your treatment or services. We may give this information to doctors, nurses, technicians, and students of affiliated healthcare programs, volunteers, or other staff who care for you. Various units may share information about you to coordinate your needs, such as lab work or drugs.

We may give details about you to people who are involved in your care, such as a specialist, spouse, or friend. Carolina Pediatrics medical personnel and employees, using their best judgment, may release to a relative, close friend, or other person information about your health related to that person's involvement in your care. Here is how your health record might be used for treatment reasons: We may send your record to specialists our doctors want to consult. (1) Your record may be sent to a doctor to whom you have been referred. (2) You may plan for a friend to pick you up after a procedure. A Carolina Pediatrics representative may believe it is in your best interest to tell your friend what drug you must take that night and what will speed your recovery at home. (3) We may use and release your health record to provide material on treatment options.

Payment. We use and release health information so that treatment and services you receive may be billed to and payment collected from you, an insurance company, or a third party. Here is how your health record might be used for payment purposes. (1) We may call your health plan for pre-approval of a service. (2) We may give your health plan details about your surgery, so it will pay us or reimburse you. (3) If someone else is responsible for your payment, we will contact that person.

Healthcare Operations. We may use and release your record to support our business functions (for example, administrative, financial, and legal activities). These uses and disclosures are needed to run the practice; support treatment and payment, and help patients receive high-quality care. Activities may include measuring quality, reviewing employee performance, and training students. Here is how your health record might be used for business operations. (1) We may call you to confirm your appointment. (2)

We may ask you to list your name and your doctor's name when you arrive for a visit. We may also call you by name in a waiting area. (3) We may use health information to review our treatment and services. (4) We may combine information on Carolina Pediatrics patients to decide what services to offer. (5) We may give information to doctors, nurses, technicians, students, and other staff for review and learning purposes. (5) We may combine our records with those from other hospitals or practices to compare how we are doing and where we can improve.

Facility Directory. Unless you object in writing, we include certain facts about you in our directory while you are a patient at Carolina Pediatrics. These facts may include your name, location, and general condition (for example, fair, serious, undetermined).

People Involved in Your Care or Payment for Your Care. Unless you object, Carolina Pediatrics health experts may tell a family member, friend, or other person you identify, or that we have a reasonable basis to believe is involved in your medical care, details about you that relate to that person's involvement in your care. If you cannot physically or mentally agree or object to a disclosure, we may supply information as needed. We may also give information to someone who pays for your care. Finally, we may share facts with someone helping in a disaster relief effort so that family can know of your condition, status, and location.

Business Associates. Business associates of Carolina Pediatrics provide some services related to treatment, payment, and business operations. Examples include medical supplies, transcription, medical record storage, and some aspects of billing. We have a written contract that requires associates to protect your record in the course of performing their job.

SPECIAL USES AND DISCLOSURES OF YOUR HEALTH RECORD

Emergencies. We may use or release your health information during emergencies.

Communication Barriers. We may use or release your record if we try to get your consent but cannot because of major communication barriers and the doctor or staff decides that you intend to consent to use or release such information.

Research. Carolina Pediatrics may release your record for research approved by the Greenville Hospital System's Institutional Review Committee (IRC). The IRC reviews proposals and protocols to ensure privacy. We may share information about you with researchers starting a project to help them find patients with specific needs (the information will not leave Greenville Hospital System).

Fundraising Events. We may use your name, address, and dates that you received treatment for Greenville Hospital System-supported fundraising events. Any fundraising material sent to you will include information telling you what to do to keep from receiving any future communications.

Workers' Compensation. We may release information about you to comply with workers' compensation laws or similar programs.

Legal Proceedings. We may release health information about you for the following reasons: Court or administrative order, and/or subpoena, discovery request, or other lawful process.

Legal Requirements. We will give out medical information about you when required to do so by federal, state, or local law.

Continued on Reverse

Serious Threat to Health or Safety. We may use and release information about you to prevent a serious threat to your health and safety or the health and safety of others.

Health Oversight Activities. We may supply information to a health oversight agency for activities authorized by law, such as audits, investigations, inspections, and licensure. These activities help the government oversee healthcare systems, benefit programs, and civil rights laws.

Public Health Risks. We may release information about you to local, state, or federal public health agencies (such as the Food and Drug Administration and the Department of Health and Environmental Control) for reasons such as: (1) To prevent or control disease, injury, or disability (2) To report births and deaths (3) To report adverse events, product defects or problems, or drug reactions (4) To note product recalls (5) To notify a person who may have been exposed to a disease or may be at risk for getting or spreading one (6) To alert a government agent if we believe a patient is the victim of abuse, neglect, or domestic violence.

Coroners, Funeral Directors, and Organ Donors. We may release information to coroners or medical examiners to identify a deceased person, find cause of death, or carry out duties as required by law. We may also give information to funeral directors to meet their duties and may share such information in the reasonable anticipation of death. We may supply your health record to organ donor groups as approved by you or consistent with the law.

Military, Veterans, and National Security. If you are a member of the armed forces, we may release information about you as required by military authorities. We may also share information about foreign military personnel to the appropriate foreign military authority. We may give information about you to federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Law Enforcement. We may release your health information to a law enforcement official: (1) In response to a court order, subpoena, warrant, summons, or similar legal process (2) To identify or locate a suspect, fugitive, witness, or missing person (3) To provide information about the victim of a crime if, under certain cases, we cannot get the person's agreement or as required by law (4) In case of a death we believe may be the result of criminal conduct (5) In response to criminal conduct at this facility (6) In an emergency to report a crime; the location of the crime or victims; or the identity, description, or location of the person who committed the crime.

Inmates. If you are an inmate of a correctional institution or in custody of a law enforcement official, we may release medical information about you to that facility or person.

YOUR HEALTH INFORMATION RIGHTS

Review and Copy. You have the right to review and request a copy of your health record (this often includes medical and billing records but, under federal law, excludes psychotherapy notes). To do so, write to Carolina Pediatrics of Greenville, 205 Enterprise Blvd. Suite 120, Greenville, South Carolina 29615. There may be a fee for copying, mailing, and related supplies. We may deny your request to inspect and copy in certain cases. Then you may request a review. Another licensed healthcare professional chosen by Carolina Pediatrics will examine your request. The reviewer will not be the person who denied your request. Carolina Pediatrics will comply with the outcome of the review.

Amend. If you believe that information we have about you is incorrect or incomplete, you may ask us to modify or add the information. You have the right to request a change or addition for as long as Carolina Pediatrics keeps the record. Request your change in writing to Carolina Pediatrics of Greenville, 205 Enterprise Blvd. Suite 120, Greenville, South Carolina 29615. You must give a reason that supports your request. We may deny your

request if it is not in writing or does not include a reason to support the request. We may also deny a request to modify a medical record in these cases: (1) The current information is accurate and complete (2) It is not part of the medical information kept by or for Carolina Pediatrics (3) It is not part of what you would be allowed to view and copy (4) It was not created by us. If we deny this request, you have the right to file a statement of disagreement. We may then prepare a rebuttal. We will give you a copy of the rebuttal.

Accounting of Disclosures. You have the right to request an "accounting of disclosures" (a list of disclosures made about you for reasons other than treatment, payment, Carolina Pediatrics operations, or national security). Request this list by writing to Carolina Pediatrics of Greenville, 205 Enterprise Blvd. Suite 120, Greenville, South Carolina 29615. Your request must state a period of time, which may not be longer than six years and may not include dates before April 14, 2003. The first list you request within a 12-month period will be free. Additional lists may involve a charge. We will notify you of the cost, and you may cancel or adjust your request before any fees are incurred.

Request Restrictions. You have the right to request that we limit information we use or give out about you for treatment, payment, or healthcare operations. You also have the right to request a limit on what we release to someone involved in your care or payment for your care, such as a family member. For example, you could ask that we not use or give out information about a surgery that you had to your family. ***We are not required to agree to your request.*** If we do agree, we will comply with your request unless the material is needed for emergency treatment. To request restrictions, submit a Restriction of Information Agreement Form to Carolina Pediatrics' registration personnel. State (1) what you want to limit; (2) if you want to limit use, release, or both; and (3) to whom the limits should apply, for example, disclosures to your family.

Request Confidential Communications. You have the right to request that we interact with you about medical matters in a certain way or place. For example, you can ask that we contact you only by mail or only at work. To request confidential communications, submit a Restriction of Information Agreement Form to Carolina Pediatrics' registration personnel. We will try to meet all reasonable requests. You must note how or where you wish to be contacted.

Paper Copy of This Notice. You have the right to a paper copy of this Notice at any time. For a paper copy, call Carolina Pediatrics at 864-454-2670 or the Greenville Hospital System Privacy Office at 864-455-3711. You may also get a copy from our web site, www.ghs.org

COMPLAINTS If you believe your privacy has been violated, you may file a complaint with Carolina Pediatrics, Greenville Hospital System or with the Secretary of the Department of Health and Human Services. To file a complaint, call the Practice Manager of Carolina Pediatrics at 864-454-2670, or call our Privacy Office at 864-455-3711 or the GHS Service Excellence Department at 864-455-7975. You may also file an anonymous complaint through our Corporate Compliance Hotline at 1-888-243-3611 (1-800-297-8592 en español). To ensure proper follow-up, complaints must also be submitted in writing.

OTHER USES. Other uses and disclosures of medical information not covered by this notice or relevant laws will be made only with your written consent. If you allow us to use or release health information about you, you may cancel that consent, in writing, at any time. If you revoke it, we will no longer use or release information for the reasons covered by your written consent. ***Note:*** We cannot take back disclosures already made with your consent.