GREENVILLE HEALTH SYSTEM

## 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: ( ) ______________
Date of Birth: ______________ SS#: ______________ Cell Phone: ( ) ______________
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: ( ) ______________
Patient Relation to Emergency Contact ______________________ Cell Phone: ( ) ______________
Secondary Contact Name: ______________________ Home Phone: ( ) ______________
Patient Relation to Emergency Contact ______________________ Cell Phone: ( ) ______________

### 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: ______________ (if different from patient) 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: ______________ (if different from patient) 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 |
| | | | | Yes No |
| | | | | Yes No |
| | | | | 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:** ______________

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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 |
|---|---|---|
| ❑ High Blood Pressure | | |
| ❑ High Cholesterol | | |
| ❑ Heart Disease | | |
| ❑ Stroke | | |
| ❑ Migraines | | |
| ❑ Seizures/Convulsions | | |
| ❑ Diabetes | | |
| ❑ Bleeding/Blood-clotting Disorder | | |
| ❑ Allergies | | |
| ❑ Asthma | | |
| ❑ Thyroid Problems | | |
| ❑ Osteoporosis | | |
| ❑ Psychiatric Disorder/Mental Illness | | |
| ❑ Alzheimer's/Dementia | | |
| ❑ Cancer - type: | | |
| ❑ Other: | | |

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## 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 ______________________________

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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 |
|---|---|---|---|
| ☐ Tetanus | | | |
| ☐ Flu | | | |
| ☐ Pneumonia | | | |
| ☐ HPV | | | |
| ☐ 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 ______________

**Cypress Internal Medicine-Patewood** **Surgical/Social/Family History**

**Please circle any existing medical problems:**

High Blood Pressure Diabetes Cholesterol Problems Reflux/Heartburn Stroke Anemia

Heart Disease (please circle if it applies: Valve Coronary Artery or Irregular Rhythm) Osteoarthritis

Osteoporosis Menopause Cancer (Type __________) Allergies Sinus Disease Psoriasis

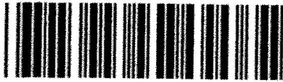
Rheumatoid Arthritis Hypothyroidism Liver Disease Kidney Disease Seizures Migraines

Headaches Diverticulosis Irritable Bowel Syndrome COPD/Asthma Depression Anxiety

Bipolar Eczema

**ROS-Please circle any symptom you have or have had recently:**

| | | |
|---|---|---|
| Significant Weight Loss/Gain | Fever/Chills | Night Sweats |
| Excessive Fatigue | Insomnia | Loss of Appetite |
| Headaches | Blurred Vision | Glasses/Contacts |
| Double Vision | Ringing in Ears | Hearing Loss |
| Sinus Drainage | Sore Throat | Hoarseness |
| Chest Pain | Palpitations | Leg Swelling |
| Short of Breath | Cough/Sputum | Wheezing |
| Severe Heartburn | Difficulty Swallowing | Nausea |
| Vomiting | Constipation | Diarrhea |
| Bloody Stools | Black Stools | Abdominal Pain |
| Painful Urination | Blood in Urine | Difficulty Voiding |
| Breast Changes/Discharge | Menstrual Changes | Hot Flashes |
| Loss of Balance | Dizziness | Blackouts |
| Seizures | Prolonged Numbness | Sexual Problems |
| Depression | Anxiety | Tremor |
| Rashes/Mole Changes | Joint Pains/Swelling | Easy Bruising |



**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)
MRN______________

DOB ______________

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

GREENVILLE HEALTH SYSTEM

## 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) ____________
- ❑ Other: (specify) ____________
- ❑ 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****

GREENVILLE HEALTH SYSTEM

# 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.