BLUE RIDGE
Women's Center

Dear Patient:

Enclosed in the letter you will find our new patient paperwork. We ask that you complete the paperwork prior to your appointment and either return it to us in the mail, fax it to us or bring it with you to your appointment. If we do not have your completed paperwork you may be asked to reschedule your appointment. If you have any questions, please phone us at 864-482-2360. You will receive a reminder call approximately 2 days before your appointment.

Appointment checklist: (please be sure to bring to your appointment)

_____ **Completed paperwork**

_____ **Detailed medication list completed** (prescription and over the counter medications) **or** you may **bring your medications in their original bottles** with you.

_____ **Insurance card(s) and a picture ID**

Your appointment is scheduled for _____ at _____ am/pm with

Dr. _____.

. ***Copays will be collected at the time of your appointment.***

Patients without health insurance are required to pay a $100 deposit. If the visit is paid in full at the time of the appointment you will receive a 20% discount.

PLEASE check with your insurance carrier as to which laboratory needs to be utilized for your pap test or if blood work is sent. We send our labs to Oconee Medical Center, however if your insurance requires us to use LabCorp or Quest, we must be advised at the time of your visit.

If you need to cancel an appointment please call our office 24-48 hours a head of time. This will allow an opening for the physician to see other patients that may be in need of an appointment.

You can reach our office staff Monday through Friday from
8:00 a.m. to 12:00 p.m. and 1:00 p.m. to 5:00 p.m.

Thank you,

Blue Ridge Women's Center

Welcome To Our Practice

We would like to take this opportunity to welcome you to our practice, and look forward to the privilege of meeting your health care needs. Please don't hesitate to let us know at any time if we are not meeting your needs or if you have questions. We have a satisfaction survey that we would like for you to complete after your visit. This will allow us to know how we can better improve our service.

As a member of Oconee Physician Practices and an affiliated health partner with Oconee Medical Center; we are dedicated to providing high quality health care. We are a local non-profit medical group sponsored by the hospital. As a result, any bill you receive from us will have the name of **Oconee Physician Practices** as well as your physician name versus the name of this individual practice location.

For your convenience, you may pay any open balances from other practices affiliated with Oconee Physician Practices at any of our locations.

<u>Please find below a list of all our practices:</u>

Between the Lakes Primary Care
Blue Ridge Women's Center
Clemson-Seneca Pediatrics
Keowee Family Urology
Mountain Lakes Community Care
Mountain Lakes ENT and Allergy Center
Mountain Lakes Internal Medicine
Oconee Heart Center
Oconee Kidney Center
Oconee Multi-Specialty Clinic
Rheumatology Consultants
Seneca Medical Associates
Upstate Family Medicine
Upstate Surgical Associates

OCONEE
Physician Practices

Patient Information

Last Name				Social Sec #	
First Name				Birth Date	
Middle Name				Sex (M or F)	
Street Address				Race	
Suite / Apt #				Primary Language	
City		State		Zip		Marital Status	
Mailing Address				Legal Guardian	
City		State		Zip		Legal Guardian's Primary Phone	
Home Phone		Work Phone		Cell Phone	
Email Address					

Guarantor Information (Person Responsible For Bill)

Last Name				Social Sec #	
First Name				Birth Date	
Middle Name				Sex (Male or Fem)	
Street Address				Relationship	
City		State		Zip		Home Phone:	
Mailing Address				Work Phone:	
City		State		Zip		Cell Phone:	

Employment Information

Patient's Employer		Employer Phone	
Spouse's Employer			

Emergency Contact Information

Name		Relationship		Phone	

Physician Information

Name of Family Physician		City/State	
Name of Referring Physician		City/State	

Insurance Information For Patient– Provide complete and provide copy of insurance card(s)

Primary Insurance Company:	Name of Insured:	Relationship to Insured:
	Birthday of Insured:	Their Social Security #:
Secondary Insurance Company:	Name of Insured:	Relationship to Insured:
	Birthday of Insured:	Their Social Security #:
Additional Insurance Company:	Name of Insured:	Relationship to Insured:
	Birthday of Insured:	Their Social Security #:

I give permission to the provider's to treat the patient. _____
Signature of Responsible Party/Self

Assignment of Benefits: I hereby authorize payment of medical benefits directly to Oconee Physician Practices for their services and to release any information acquired in the course of my examination or treatment for insurance purposes. I understand that records may be transmitted electronically or by mail as required.

Signature Of Patient Or Guardian >> _____ **Date:** _____

BLUE RIDGE
Women's Center

Patient Medical/Surgical History Questionnaire

Name_____ Date of Birth: _____ Today's Date_____

Referred By_____

Reason for Visit_____

Allergies (None ☐) _____

OB-Gyn History

Date of last menstrual period_____
Age at first period_____
How often do you have a period? _____
Days of flow_____
Number of pads/tampons used on heaviest day_____
Pain or cramps Y N
Do you ever miss school/work because of your period Y N

Sexually active Y N
Method of birth control_____
Abnormal Paps Y N
New or changing lump in the breast Y N

Additional Concerns _____

Immunizations (Please enter date of most recent)

Flu_____ Gardasil_____ Pneumonia_____ Tetanus_____ Zostavax_____

Procedures (Please enter date of most recent)

Pap_____ Mammogram_____ Bone Density_____ Colonoscopy_____

Deliveries

Number of times pregnant_____
Number of miscarriages/abortions_____

DATE	WEEKS	WT OF BABY	TYPE DELIVERY	COMPLICATIONS

Surgeries (List every surgery and date)

_____
_____
_____
_____

Social History

Smoke Y N Packs per day/week_____

Alcohol Y N units per day _____(a unit is 8oz. beer, 4 oz. wine or 1 oz. liquor)

Caffeine Y N

Street Drugs Y N

Family History

	Relationship		Relationship
Alcoholism		Heart disease	
Bleeding disorder		High blood pressure	
Blood clots		Mental illness	
Cancer		Stroke	
Diabetes		Thyroid Problems	
Osteoporosis			

Medical Conditions

Check all that you have or have had, check "C" for Current conditions & "P" for Past conditions

Cardiac/Blood vessels	C	P
no problem		
anemia		
arrhythmia		
bleeding tendency		
blood clots		
high blood pressure		
high cholesterol		
poor circulation		
Neurologic		
no problem		
migraines		
multiple sclerosis		
neuropathy		
Parkinsons		
seizures		
stroke		
TIA		
tremor		
Infection		
no problem		
Hepatitis A B C		
HIV/AIDS		
MRSA		
Skin		
no problem		
open sore		
rash		

Respiratory	C	P
no problem		
allergies		
asthma		
bronchitis		
COPD		
difficulty breathing		
pneumonia		
sleep apnea		
TB		
Musculoskeletal		
no problem		
arthritis		
back/neck problems		
difficulty walking		
fibromyalgia		
fracture		
limited movement		
Mental Health		
no problem		
anxiety		
chemical dependency		
chronic pain		
dementia		
depression		
insomnia		
bad nerves		

GI	C	P
no problem		
irritable bowel syndrome		
acid reflux		
colitis		
difficulty swallowing		
diverticulitis		
hemorrhoids		
hernia		
liver disease		
ulcer		
Urinary		
no problem		
incontinence		
kidney stones		
urinary tract infection		
Endocrine		
no problem		
Adrenal disease		
Diabetes		
Thyroid disease		
Eye/Ear		
no problem		
glaucoma		
glasses/contacts		
hearing loss/aid		
Cancer		
no problem		
type		

- o **Between the Lakes**
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- o **Mountain Lakes Community Care**
- o **Mountain Lakes ENT & Allergy Center**
- o **Mountain Lakes Internal Medicine**
- o **Oconee Geriatric & Palliative Medicine**
- o **Oconee Heart Center**
- o **Oconee Kidney Center**
- o **Rheumatology Consultants**
- o **Seneca Medical Associates**
- o **Upstate Family Medicine**
- o **Upstate Surgical Associates**

Release of Information Authorization Form

Acknowledgement of Receipt of Notice of Privacy Practices and Financial Policy

This signed form acknowledges that you have received a copy of our practice's Notice of Privacy Practices as required by Federal Law and our Financial Policy. By signing below you are acknowledging that you understand and have read the notices. The notices are yours to keep.

With whom may we discuss patient's financial information?

Patient Only: [ ]

Name: _____ Relationship: _____
For patient over age of 18 only

Name: _____ Relationship: _____
For patient over age of 18 only

May we leave messages regarding appointments?

(Messages regarding any other information will be left as call back request only)

☐ YES _____
What Phone Number

☐ NO

With whom may we discuss patient's medical information?

Patient Only: [ ]

Name: _____ Relationship: _____
For patient over age of 18 only

Name: _____ Relationship: _____
For patient over age of 18 only

_____
Print Patient Name

_____
Patient Date of Birth

_____ _____
Signature of Guarantor/ Patient/ Legal Guardian Date

OCONEE
Physician Practices

FINANCIAL POLICY

COLLECTION OF PATIENT AMOUNTS DUE

Insurance companies require that we collect any co-pay or co-insurance amounts at the time of service. We will collect the co-pay amounts at the time of check-in to avoid a wait at check-out. All co-insurance amounts will be collected at the time of check-out. Please understand that you will be responsible for any amounts not paid by your insurance company. OPP also offers a 20% discount to uninsured patients if the balance is paid at the time of service or within 30 days of the visit.

We understand that temporary financial problems may effect timely payment of your balance. We encourage you to communicate any such problems so that we may assist you in the management of your account.

We understand that there may be special agreements between parents regarding a child's medical expenses. However, the parent that brings the child in for a visit is responsible for making payment on that date of service.

PRESCRIPTION REFILL REQUESTS BY PHONE

We will generally need to see an existing patient back in the office prior to calling in a prescription. However, in rare cases where it's appropriate to write the prescription, there will be a $15.00 charge in order to cover operating costs. This is not generally covered by your insurance.

DISMISSAL OF PATIENTS FOR FINANCIAL REASONS

Patients can be dismissed from the practice for a number of reasons, including the following financial situations:

1. Collection Agency Turnover will result in a dismissal from the practice if a patient fails to pay his or her balance within thirty days of turnover.
2. Expedited dismissal occurs when a patient is not honoring his or her financial responsibilities.

All patients should be given at least thirty days notice before being dismissed from practice unless instructed otherwise by physician.

This notice is yours to keep.

301 Memorial Drive, Suite F ● Seneca, SC 29672 ● (864) 885-7989 ● FAX (864) 885-7867