



**GREENVILLE  
HEALTH SYSTEM**

Mountain Lakes  
Family Medicine

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. The attached New Patient Pack needs to be filled out completely, and turned in prior to scheduling your appointment. If you have any questions do not hesitate to call our office.

**New Patient Visit Check List:**

Please be sure to bring the below to your appointment:

\_\_\_\_\_ Medication bottles (bring to every appointment) including over the counter medications and herbal remedies

\_\_\_\_\_ Insurance card (s) and picture ID

\_\_\_\_\_ Copayment/ or payment due at time of service for uninsured

**What to Expect at your New Patient Visit**

At your initial appointment, your height, weight, temperature, pulse and blood pressure will be checked. We will go over your medical, family, and social history. The provider will do a limited exam and order any necessary diagnostic tests. Please be aware that complete physicals and pelvic exams will not be done at your initial new patient visit. A follow up visit will be scheduled for you at check out if necessary.

Please be aware that any cultures/labs done at our office will go to Oconee Memorial Hospital. If your insurance does not cover our lab please ask provider for lab slip to bring to the lab of your choice.

It is our policy not to prescribe controlled substances on a routine basis. If deemed necessary by the physician a referral to a specialist or pain management may be scheduled.

**Office Courtesies**

A 48 business hours notice is required for all call in prescriptions. Please do not wait until you are out of a medication to call for a refill.

10110 Clemson Blvd • Seneca, SC 29678 • 864-482-3148 P 864-482-0505 F  
Kevin R. Saunders MD • Linda Booth DO



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**New Patient with controlled medications:**

It is our policy not to prescribe controlled substances on the first visit.

For patients already on controlled medications, the discretion to continue these medications will be at the discretion of the physician based on clinical evaluation and documentation.

A referral to pain management or specialist may be schedule.

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_



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: \_\_\_\_\_



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	_____	_____
	_____	_____
	_____	_____
	_____	_____



## 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.

**TELEMEDICINE:** Health care services may be provided via telemedicine which involves the use of electronic communications to enable health care providers at different locations to share individual patient medical information for the purpose of improving patient care. The information may be used for diagnosis, therapy, follow-up and/or education, and may include any of the following: Patient medical records, medical images, live two-way audio and video, Output data from medical devices and sound and video files. Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption

**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. I hereby consent to receive autodialed and/or pre-recorded calls regarding my outstanding balance, if any, from or on behalf of GHS and/or GHS Partners in Health, Inc. at the telephone number(s) that I have provided to GHS and/or GHS Partners in Health, Inc.

**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.

**HEALTHCARE ASSOCIATED INFECTIONS:** Healthcare-associated infections can be a complication of hospitalization. South Carolina has a public reporting law: Hospital Infections Disclosure Act, S.C. code Ann. Section 44-7-2410, which requires hospitals to monitor and report targeted healthcare associated infections to the Department of Health and Environmental Control (DHEC). These reports are available on the following website for public view: <http://www.scdhec.gov/Health/FHPF/InfectionControlHIDA/HospitalInfectionControl/>

### CHART COPY

100797 (12/15)  
CONSENTS/REGISTRATION



Consents/Registration  
Greenville Health System

**CONSENT AND AUTHORIZATION - UMG**

**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)





**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: \_\_\_\_\_

**Informed Consent and Treatment  
Agreement for Controlled Substances****Patient Name:** \_\_\_\_\_ **MRN/DOB:** \_\_\_\_\_

Your physician has indicated that a controlled medication may assist in your symptomatic relief. Controlled medicine can be dangerous and habit forming. These medicines must be taken only as prescribed by your doctor. Please read this consent and agreement thoroughly and ask any questions you may have.

**If you are in agreement and fully understand the benefits and risks of the medications, sign and date below.**

- I understand that the medication I am being prescribed may cause addiction, but my physician feels it is necessary for treatment of my condition. My physician has explained to me the potential risks, the potential short and long term side effects; the risk of drug interactions and over-sedation; the risk of misuse and overdose. I accept these risks.
- I agree to take this medication only as prescribed by my physician.
- I agree to attend all scheduled appointments with my physician, PA or Medical Assistant.
- I understand that refills will not be given early.
- I will not obtain controlled substances from any other providers unless authorized by my primary prescriber, because it may be considered illegal to obtain controlled substances from multiple providers.
- I understand that these medications are for my personal use only.
- I understand that it is illegal, and can be reported to the police, to give or sell my medication to others.
- I agree to not use any illegal substances, including but not limited to marijuana, cocaine, or any other "street drugs".
- I understand that it is illegal for me to use medications that are not prescribed to me.
- I understand that I am responsible for my own medication. Lost or stolen medication will not be replaced.
- I give up the right to privacy protections with regard to my prescription for controlled substances. The physician or his staff may talk with other physicians, pharmacists or family members to confirm appropriate medication use.
- I agree to submit to random drug screening tests when ordered by my physician, and I will be responsible for payment for the tests.
- If requested of me, I agree to bring my medication bottle(s) to the office for the purpose of a pill count.
- I understand that I may obtain my controlled substances from only one pharmacy and it will be in South Carolina, and I agree to update my physician's office of any changes in the pharmacy I use.
- I understand these medications may interfere with my ability to drive and/or operate heavy machinery.

**Certification**

- I have reviewed this Informed Consent and Treatment Agreement for Controlled Substances. I understand it and continue to agree to honor the Agreement. I understand that failure to do so may result in my discharge from this medical practice.

**Patient Signature: (or legally authorized representative):** \_\_\_\_\_**Date:** \_\_\_\_\_**Witnessed by:** \_\_\_\_\_**Original Prescribing Provider Signature:** \_\_\_\_\_**Time:** \_\_\_\_\_**This agreement was entered on this date:** \_\_\_\_\_ **(MM/DD/YY)**

## 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.