



GREENVILLE  
HEALTH SYSTEM

#### Premier Women's Care

209 Three Bridges Road  
Greenville, SC 29611  
(864) 220-4209 P  
(864) 241-9207 F  
[www.premierwomenscare.com](http://www.premierwomenscare.com)  
[ghs.org](http://ghs.org)

### Welcome New Patient to Premier Women's Care!

Thank you for choosing Premier Women's Care! We understand that every woman is unique. Our physicians begin each office visit by listening to the patient, the most important part of patient assessment. Then they will conduct a thorough medical examination. Together with the physician a customized healthcare plan will be created.

We offer comprehensive medical services that cover a wide range of services, including annual exams, pap smears, birth control, breast care, gyn surgery, health screening, incontinence, infertility services, mole removal, nutrition counseling, pregnancy care, and ultrasound and weight management.

There are a few things that will help us with your first visit with us. Please request your records from you previous OB/GYN, so they will arrive before your appointment date. Bring your insurance card and a picture ID with you. If your insurance requires authorization from your primary care provider, please have them fax the authorization to our office before your appointment date. You will be expected to pay your co-pay at the time of service. If you do not have insurance, you will be expected to pay for your visit at the time of service.

Please arrive at least 15 minutes prior to your appointment time to allow for completion of your registration. Please complete the enclosed information sheets before you arrive. Our office requires 24 hours' notice. There could be a fee assessed for a missed Appointment. We have included the directions for our facility on the back for your convenience.

We look forward to seeing you!

Premier Women's Care Staff  
[www.premierwomenscare.com](http://www.premierwomenscare.com)

Carreen E. Drake, MD  
Catherine H. Frederick, MD  
Toni D. Hogan, MD  
Emily H. Turney, MD

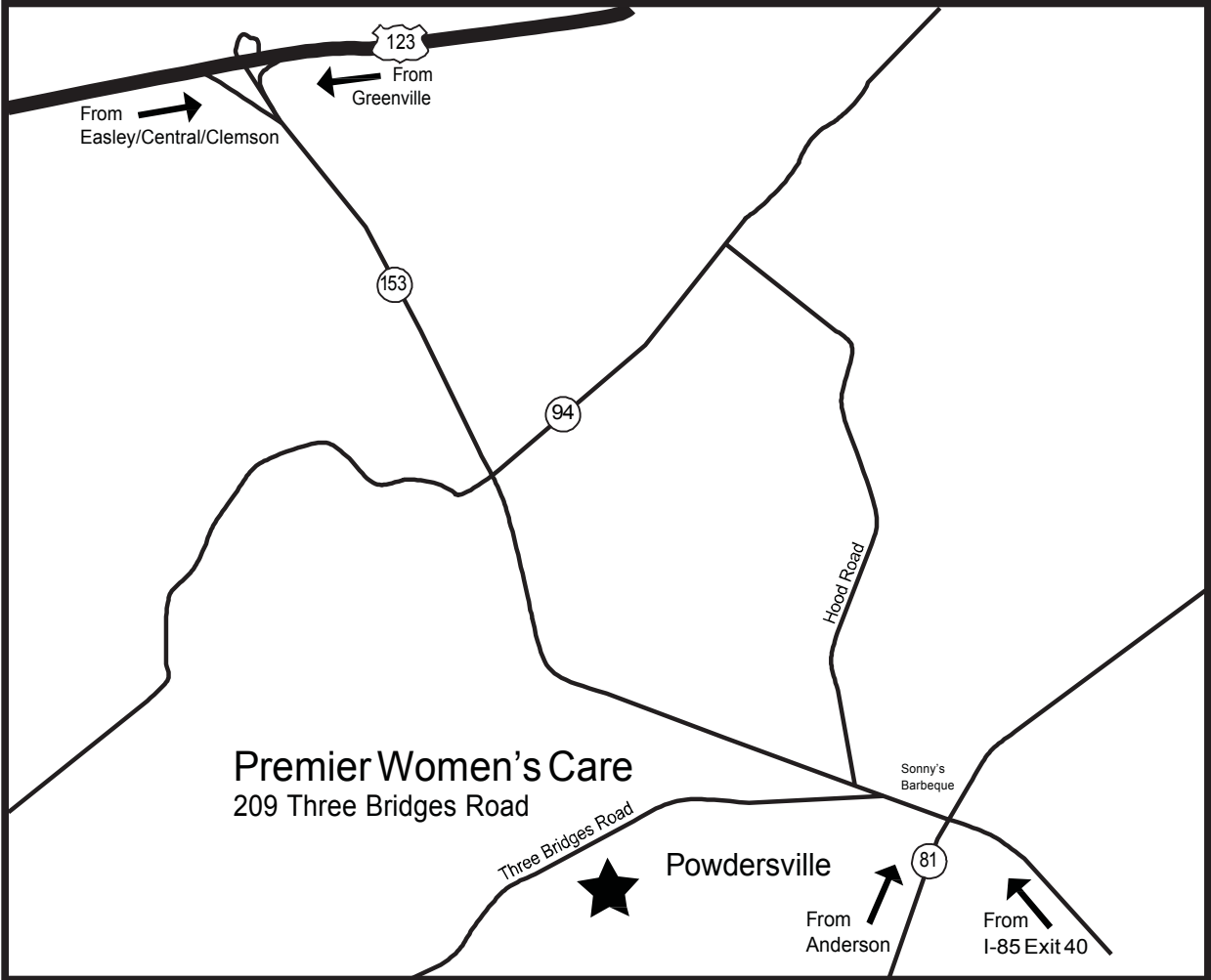
# Premier Women's Care

209 Three Bridges Road • Greenville, SC 29611  
(864) 220-4209

Premier Women's Care is just off SC 153

From I-85:  
Take Exit 40 (SC 153) and go toward Easley. Turn left onto SC 74 (Three Bridges Road).  
Premier Women's Care is straight ahead.

From Easley:  
Take US 123 to SC 153 South. Turn right onto SC 74 (Three Bridges Road).  
Premier Women's Care is straight ahead.





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	_____	_____
	_____	_____
	_____	_____
	_____	_____



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



## 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.



**Uninsured Discount Protocol**

The following is the protocol for services provided to self-pay - non-insured - patients 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 University Medical Group or GHS UMG for the patient whose name appears below.

An uninsured discount of 30% will be applied at the date of service for patients who do not have insurance (self-pay or non-insured) or who are having a service(s) that is not covered by the insurance carrier. Effective for dates of services rendered on or after July 1, 2008.

Services that are **not included** in the discount are acupuncture, cosmetic and infertility evaluation or treatment services, elective materials and supplies, such as contraceptives, durable medical equipment, injections, as well as other contractual agreements with outside companies.

**Note for services not covered by the insurance carrier:**

If services are not covered by the insurance carrier and will be paid by the patient, the patient is to be registered as self-pay and is aware GHS will not be billing the insurance company.. (This does not apply to package rates such as plastic surgery or MFS.)

*The discount cannot be applied:*

- A. *If the insurance has been billed and the patient was not aware the services were non-covered. There may be extenuating circumstances which would be reconsidered, such as if the patient informed GHS prior to the procedure the procedure was non-covered and the insurance company was billed anyway. GHS would acknowledge the error and adjust accordingly.*
- B. *If a high balance is left after for the patient after insurance adjustments have been applied and/or insurance has paid or applied the charges to the deductible.*

**Collection Policy:** The balance will be due upon receipt of services, and the patient will have 90 days from the date of service to pay it in full before it will be sent to the collection agency. Delinquent accounts will be forwarded to a collection agency. GHS will inform the patient of his/her account status on a billing statement. Please call us at 864-454-2000 or 1-888-284-6024 if you have questions. GHS will attempt to contact the patient by letter before the account is forwarded.

**Patient Agreement:**

I acknowledge the above stipulations of my uninsured discount.

**Note: If you have received this form by mail; you have 15 days to return it.**

**Signatures:** I have read and understand the uninsured discount protocol.

**Print** Patient's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date of Service: \_\_\_\_\_

Patient/Personal Representative Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Print** Name of Personal Representative: \_\_\_\_\_

Relationship of Representative to Patient: \_\_\_\_\_

**Please note that this form must be signed separately for each date of service for which the patient would like the discount.**

GHS UMG Representative/Title: \_\_\_\_\_ Date: \_\_\_\_\_