GHS UNIVERSITY MEDICAL GROUP

ADULT PATIENT INFORMATION

PATIENT INFORMATION

Full Name: ______________________________ Nickname/AKA: ______________

Last *First* *Middle*

Maiden Name: ______________ Date of Birth: ______________

Month/Day/Complete Year

Address: ______________________________ SS#: ______________

______________________________ Sex *(Male or Female)*: ______________

City, State, Zip: ______________________________

County: ______________ Home Phone: ( )

PO Box: ______ (Required if applicable) Cell Phone: ( )

City, State, Zip: ______________________________

Preferred language: ______________ Preferred E-mail: ______________

Marital Status: ______________ Race: ______________

Single, Married, Divorced, Widowed, Partnered

Caucasian (white), Native American, African-American (black), Latin, Asian, other

EMPLOYMENT

Employer: ______________________________

Address: ______________________________

______________________________ Work Phone: ( )

City, State, Zip: ______________________________

EMERGENCY CONTACT

Only one (1) emergency contact is required

Name: ______________________________ Home Phone: ( )

Address: ______________________________ Cell Phone: ( )

City, State, Zip: ______________________________ Work Phone: ( )

Relationship: ______________ Employer Name: ______________

Optional

Name: ______________________________ Home Phone: ( )

Address: ______________________________ Cell Phone: ( )

City, State, Zip: ______________________________ Work Phone: ( )

Relationship: ______________ Employer Name: ______________

UNIVERSITY MEDICAL GROUP

DISCLOSURE OF MEDICAL INFORMATION

Disclosure of Medical Information: Your medical information and communication of that information is essential to your care. We prefer to speak directly with each patient but we understand that other individuals or family members may have knowledge of and be assisting in your care. Please list the individuals who we are authorized to discuss your care with. (NOTE: We can not discuss your care with others, including spouses or other family members living with you, unless they are listed below.)

Name of Person	Relationship to Patient
____________________	____________________
____________________	____________________

Confidential Communication: Communication between this practice and you, the patient, is critical to your health. Please list the phone number(s) where we can reach you.

Home: ____________________ Work: ____________________

Cell phone: ____________________ Other: ____________________

If we are unsuccessful at reaching you at the above phone numbers, please list others who we can contact to get a message to you to call our office. *An automated appointment reminder system will call your home number listed in our data base.*

Name of Person	Phone Number	Relationship to Patient
____________________	____________________	____________________
____________________	____________________	____________________

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

At home At work On my cell phone I do not authorize

I authorize any medical information regarding myself to be left on the following answering machine or voice mail

(Check all that apply) At home At work On my cell phone I do not authorize

Signatures: I hereby authorize the use or disclosure of the personal health information as described above.

Patient/Personal Representative Signature: ______________________________ Date: ______________

PRINT Name of Personal Representative: ______________________________

Relationship of Representative to Patient: ______________________________

GHS UMG Representative: ______________________________ Date: ______________

Note: This restriction applies only to care provided by the Greenville Hospital System University Medical Group practice identified in the upper left hand corner of this form. Other providers involved in your treatment may require you to complete a separate request for restriction. Either you or UMG may terminate this restriction by completing the following. **The below signature is to be used if you would like to make the above information terminate on a certain date.**

This agreement is terminated as of ______________ Signature ______________________________ *(Date)* __________

Patient Full Name (PRINT) ______________________________ DOB ____________________

UNIVERSITY MEDICAL GROUP

Greenville Hospital System
University Medical Group*

FINANCIAL POLICY

Patient Full Name (PRINT) ____ DOB _________________________

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 by Greenville Hospital System, GHS Partners in Health, and the various entities and providers affiliated with them each individually and collectively referred to as Greenville Hospital System University Medical Group or GHS UMG for the patient whose name appears above.

Payment for Service: Our office will inform you of the amount due when you check out. This amount is 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 $15.00
- 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 cancelled 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 the number listed above during normal office hours.

Payment for Services Provided by Certain Non-UMG 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 Hospital 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.

Signatures: I have read and understand these financial policies.

Patient/Personal Representative Signature: ____ Date: _________________

PRINT Name of Personal Representative: ____

Relationship of Representative to Patient: ____

GHS UMG Representative: ____ Date: _______________

3-10-09

GHS UNIVERSITY MEDICAL GROUP **PEDIATRIC PATIENT INFORMATION**

PATIENT INFORMATION

Full Name: ______________________________ Preferred Name: ____________
Last First Middle

Date of Birth: ____________
Month / Day / Complete Year

Address: ______________________________ SS#: ____________

______________________________ Sex *(Male or Female)*: ____________

City, State, Zip: ______________________________

County: ____________ Home Phone: ( )

PO Box: ________ (Required if applicable) Cell Phone: ( )

City, State, Zip: ______________________________

Preferred language: ____________ Preferred Email: ____________

Race: ____________
Caucasian (white), Native American, African-American (black), Latin, Asian, other

EMERGENCY CONTACT *(other than parent(s)/guardian)*

Name: ______________________________ Home Phone: ( )

Address: ______________________________ Cell Phone: ( )

City, State, Zip: ______________________________ Work Phone: ( )

Relationship: ____________

PARENT/GUARDIAN & IMMEDIATE FAMILY INFORMATION

MOTHER

Full Name: ______________________________ Preferred Name: ____________

Last First Middle

Maiden Name: ____________ Date of Birth: ____________
Month / Day / Complete Year

Address: ______________________________
if different from patient

SS#: ____________

City, State, Zip: ______________________________ Home Phone: ( )

Cell Phone: ( )

Employer: ______________________________

Work Phone: ( )

FATHER

Full Name: ______________________________ Preferred Name: ____________
Last First Middle

Date of Birth: ____________
Month / Day / Complete Year

Address: ______________________________
if different from patient

SS#: ____________

City, State, Zip: ______________________________ Home Phone: ( )

Cell Phone: ( )

Employer: ______________________________

Work Phone: ( )

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

Patient Name: ____________________ DOB: ____________________

GHS UNIVERSITY MEDICAL GROUP

BILLING INFORMATION

ACCIDENTAL INJURY

Is visit result of an accident? (Examples: auto accident, workers compensation, etc.) YES / NO Date: ____________

GUARANTOR INFORMATION *(This is the person responsible for the balance after insurance pays on the account.)*

Parent/guardian *presenting minor child for treatment will be listed as the guarantor. This person will be responsible for any balances due after insurance has paid.* ***If 18 or older,*** *you are your own guarantor and do not have to complete this section unless there is a legal designation for your care, such as a power of attorney.*

*******IF SELF DO NOT COMPLETE THIS SECTION BELOW*******

Guarantor Name: ____________________ Guarantor SS#: ____________________
(Last First Middle)

Relationship: ____________________ Primary Phone: ( ) ____________

Address: ____________________ Alternate Phone: ( ) ____________

City, State, Zip: ____________________

PO Box: ____________ (Required if applicable)

City, State, Zip: ____________________

Guarantor Employer: ____________________ Work Phone: ____________

PRIMARY INSURANCE INFORMATION

If SELF check this box ☐

Insurance Co. Name: ____________________

ID#: ____________________ Effective Date: ____________

Patient Employment Status: ____________
(full-time, part-time, unemployed, retired, military, retired military, full or part-time student)

SUBSCRIBER INFORMATION (This is the person insured by the insurance company listed above.)

*******IF SELF DO NOT COMPLETE THIS SECTION BELOW*******

Patient Relationship to Subscriber: ____________________

Subscriber's Full Name: ____________________ Sex: ______ Date of Birth: ____________
M or F

Address: ____________________ SS#: ____________________

City, State, Zip: ____________________ Phone: ( ) ____________

Employer: ____________________ Work Phone: ( ) ____________

SECONDARY INSURANCE INFORMATION

Insurance Co. Name: ____________________

ID#: ____________________ Effective Date: ____________

Patient Employment Status: ____________
(full-time, part-time, unemployed, retired, military, retired military, full or part-time student)

SUBSCRIBER INFORMATION (This is the person insured by the insurance company listed above.)

*******IF SELF DO NOT COMPLETE THIS SECTION BELOW*******

Patient Relationship to Subscriber: ____________________

Subscriber's Full Name: ____________________ Sex: ______ Date of Birth: ____________
M or F

Address: ____________________ SS#: ____________________

City, State, Zip: ____________________ Phone: ( ) ____________

Employer: ____________________ Work Phone: ( ) ____________

AUTHORIZATION

I authorize medical evaluation & treatment, and release of information for insurance/medical purpose concerning my illness and

Signature of Patient/Guardian/Guarantor: ____________________ Date: ____________

Patient Name: ____ DOB: ________________________________

treatment. I hereby, authorize payment from my insurance company to the Greenville Hospital System, University Medical Group for services rendered. I will be responsible for any amount not covered by my insurance.

Signature of Patient/Guardian/Guarantor: ____ Date: ____________________