

PATIENT INFORMATION

Full Name: _____
Last First Middle

Preferred 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 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: _____
Last First Middle

Preferred Name: _____

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: _____
Last First Middle

Preferred Name: _____

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

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.)

<u>Name of Person</u>	<u>Relationship to Patient</u>
_____	_____
_____	_____

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.*

<u>Name of Person</u>	<u>Phone Number</u>	<u>Relationship to Patient</u>
_____	_____	_____
_____	_____	_____

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 _____

**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: _____

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: _____ (Last First Middle) Guarantor SS#: _____
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: _____