Christie Pediatric Group

Patient Registration Packet

Please fill out the attached forms as completely as possible and bring them with you to your visit. PLEASE – DO NOT FAX THIS PACKET.

We care about your child's total health and knowing the medical history can help us provide the best care for child's needs.

Thank you for your time and patience. Let us know if you have any questions.

Doctors Offices at:
9 Mills Ave, Greenville, SC 29605
3911 S. Hwy 14, Greenville, SC 29615
1409 W. Georgia Rd, Suite A, Simpsonville, SC 29680

Visit our websites at:
www.ghschildrens.org/christiepeds
www.christiepediatricgroup.com

GREENVILLE HEALTH SYSTEM

Patient Information

(Please print)

Full Legal Name: ____________________ Preferred Name: ____________
Last *First* *Middle*

Sex: ☐ Male ☐ Female

Date of Birth: ____________ SS#: ____________
Month/Day/Complete Year

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: ____________________ Patient relation to Guarantor: ____________
Last *First* *Middle*

Home Phone: ( ) ____________

Date of Birth: ________ SS#: ____________ Cell Phone: ( ) ____________

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: ( ) ____________

Patient Relation to Emergency Contact ____________________ Cell Phone: ( ) ____________

Secondary Contact Name: ____________________ Home Phone: ( ) ____________

Patient Relation to Emergency Contact ____________________ Cell Phone: ( ) ____________

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: ____________________ Nickname: ____________
Last *First* *Middle*

Date of Birth: ____________
Month / Day / Complete Year

SS#: ____________

Home Address: ____________ City: ________ State: ______ Zip: ______
(if different from patient)

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: ____________________ Nickname: ____________
Last *First* *Middle*

Date of Birth: ____________
Month / Day / Complete Year

SS#: ____________

Home Address: ____________ City: ________ State: ______ Zip: ______
(if different from patient)

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
				Yes No
				Yes No
				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:**____________

GREENVILLE HEALTH SYSTEM

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 ____

GREENVILLE
HEALTH SYSTEM

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
❏ Tetanus			
❏ Flu			
❏ Pneumonia			
❏ HPV			
❏ 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		

GREENVILLE HEALTH SYSTEM

Today's Date ____________ Patient Name ______________________ DOB ____________

Hospitalization & Surgical History – List all hospital admissions and operations you have had.

Reason for Hospitalization/Surgery	Year
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	

❏ Yes ❏ No Did you have any problems with anesthesia? If yes, please describe.

____

Social History

❏ Yes ❏ No Do you currently smoke or use other tobacco products? If yes, how many per day? ____________

❏ Yes ❏ No Have you smoked or used other tobacco products in the past? If yes, how many per day? ____________

How many years since you last smoked? ____________

❏ Yes ❏ No Do you drink caffeinated beverages? If yes, what type, how often, how much? ____________

❏ Yes ❏ No Do you drink alcohol? If yes, what type, how often, how much? ____________

❏ Yes ❏ No Do you exercise regularly? If yes, what type? ____________

How often and how long? ____________

Family Medical History – Check the box next to any medical condition below that has affected any of your immediate family members (parents, brothers, sisters), state your relationship and their age at onset.

	Relationship	Age at onset
❏ High Blood Pressure		
❏ High Cholesterol		
❏ Heart Disease		
❏ Stroke		
❏ Migraines		
❏ Seizures/Convulsions		
❏ Diabetes		
❏ Bleeding/Blood-clotting Disorder		
❏ Allergies		
❏ Asthma		
❏ Thyroid Problems		
❏ Osteoporosis		
❏ Psychiatric Disorder/Mental Illness		
❏ Alzheimer's/Dementia		
❏ Cancer - type:		
❏ Other:		

Vaccines for Children (VFC) Program
Patient Eligibility Screening Record Form

A record of all children 18 years of age or younger who receive immunizations must be kept in the health care provider's office for 3 years or longer depending on state law. The record may be completed by the parent, guardian, individual of record, or by the health care provider. VFC eligibility screening and documentation of eligibility status must take place with each immunization visit to ensure the child's eligibility status has not changed. While verification of responses is not required, it is necessary to retain this or a similar record for each child receiving vaccine. Providers using a similar form (paper-based or electronic) must capture all reporting elements included in this form.

1. Child's Name: ____ 2. Child's Date of Birth: __ __/__ __/__ __ __ __
Last Name First Name MI

3. Parent/Guardian/Individual of Record:____
Last Name First Name MI

4. Provider's Name:____
Last Name First Name MI

5. To determine if a child (0 through 18 years of age) is eligible to receive publicly funded vaccine through the VFC or state programs, at each immunization encounter/visit enter the date and mark the appropriate eligibility category. *If Column A-D is marked, the child is eligible for the VFC program. If column E, F or G is marked the child is not eligible for federal VFC vaccine.*

	Eligible for VFC Vaccine				Not eligible for VFC Vaccine		
	A	B	C	D	E	F	G
Date of Immunization visit	Medicaid Enrolled (VFC stock)	No Health Insurance (VFC stock)	American Indian or Alaska Native (VFC stock)	VFC [1]Underinsured served by FQHC, RHC or deputized provider (VFC stock)	Has health insurance that covers vaccines (Private stock)	[2]SC State Underinsured, Served by Non-FQHC/RHC (State stock)	[3]SC State Insured, Insured Hardship, Vaccine Caps (State stock)

[1]*Underinsured includes children with health insurance that does not include vaccines or only covers specific vaccine types. Children are only eligible for vaccines that are not covered by insurance. In addition, to receive VFC vaccine, underinsured children must be vaccinated through a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) or under an approved deputized provider. The deputized provider must have a written agreement with an FQHC/RHC and the state/local/territorial immunization program in order to vaccinate underinsured children.*

[2]*SC State Vaccine Program Underinsured: These children are underinsured but are not eligible to receive federal vaccine through the VFC program because the provider or facility is not an FQHC/RHC or a deputized provider. However, these children may be served with state vaccine program vaccine to cover these non-VFC eligible children. Only providers enrolled in the SC State Vaccine Program are eligible to serve this population. You must have SC State Vaccine program vaccine stock prior to seeing this patient population.*

[3]*SC State Vaccine Program - Insured Hardship and Vaccine Caps: These children are considered insured and are not eligible for vaccines through the VFC program. However, these children may be served state vaccine program vaccine to cover these non-VFC eligible children. Insured Hardship is defined as "Health Insurance deductible is greater than $250.00 per child or $500.00 per family (Eligible for state vaccine only if the deductible has not been met and the family cannot afford to pay for vaccine)." Vaccine Caps is defined as "Insured but coverage capped at certain amount and cap has been exceeded." The Human Papillomavirus Vaccine is excluded from the SC State Vaccine Program. Only providers enrolled in the SC State Vaccine Program are eligible to serve this population. You must have SC State Vaccine program vaccine stock prior to seeing this patient population.*

South Carolina Department of Health and Environmental Control

Vaccines For Children (VFC) Program Patient Eligibility Screening Record Form

Purpose:

The purpose of this form is to provide screening and documentation of the eligibility status at each immunization encounter (visit) for the Vaccines for Children (VFC) program for children 18 years of age or younger, prior to administration of vaccine(s). In addition, screening and documenting eligibility status for the state vaccine eligible child through the South Carolina State Vaccine Program at each immunization encounter (visit). This form captures the documentation for screening all categories of VFC and non-VFC eligible children seen in the VFC provider's office during immunization encounters (visits). Screening and Documentation of eligibility statuses is a requirement for all providers enrolled in the vaccine programs.

General Instructions for Use:

The Vaccines For Children (VFC) Patient Eligibility Screening Record Form will be completed by the parent, guardian, individual of record, or healthcare provider staff **prior** to administration of vaccine(s) for every immunization encounter (visit).

Item-By-Item Instructions:

1. Complete the Child's Name, Child's Date of Birth, Parent/Guardian/ Individual of Record, and Provider's Name.
2. Assess client's eligibility for publicly funded vaccine. Record the date of the immunization encounter (visit).
3. After determination of eligibility category, mark in the appropriate column:

Eligible for VFC Vaccine

A. Medicaid- Enrolled (VFC Stock)
B. No Health Insurance (VFC Stock)
C. American Indian or Alaska Native (VFC Stock)
D. [1]Underinsured, served by FQHC, RHC or deputized provider (VFC Stock)

Not eligible for VFC Vaccine

E. Has health insurance that covers vaccines (Private Stock)
F. [2]SC State Underinsured, served by Non-FQHC/RHC (State Stock)
G. [3]SC State Insured, Insured Hardship, Vaccine Caps (State Stock)

Office Mechanics and Filing:

Private Provider:

The completed Vaccines For Children (VFC) Patient Eligibility Screening Record Form must be kept for (3) years from most recent "date of immunization visit."

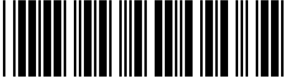
[1]*Underinsured includes children with health insurance that does not include vaccines or only covers specific vaccine types. Children are only eligible for vaccines that are not covered by insurance. In addition, to receive VFC vaccine, underinsured children must be vaccinated through a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) or under an approved deputized provider. The deputized provider must have a written agreement with an FQHC/RHC and the state/local/territorial immunization program in order to vaccinate underinsured children.*

[2]*SC State Vaccine Program Underinsured: These children are underinsured but are not eligible to receive federal vaccine through the VFC program because the provider or facility is not an FQHC/RHC or a deputized provider. However, these children may be served with state vaccine program vaccine to cover these non-VFC eligible children. Only providers enrolled in the SC State Vaccine Program are eligible to serve this population. You must have SC State Vaccine program vaccine stock prior to seeing this patient population.*

[3]*SC State Vaccine Program - Insured Hardship and Vaccine Caps. These children are considered insured and are not eligible for vaccines through the VFC program. However, these children may be served state vaccine program vaccine to cover these non-VFC eligible children. Insured Hardship is defined as "Health Insurance deductible is greater than $250.00 per child or $500.00 per family (Eligible for state vaccine only if the deductible has not been met and the family cannot afford to pay for vaccine)." Vaccine Caps is defined as "Insured but coverage capped at certain amount and cap has been exceeded." The Human Papillomavirus Vaccine is excluded from the SC State Vaccine Program. Only providers enrolled in the SC State Vaccine Program are eligible to serve this population. You must have SC State Vaccine program vaccine stock prior to seeing this patient population.*

DHEC:

File in Patient's medical record.



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:_____________
Form Create Date: December 30, 2013

GREENVILLE HEALTH SYSTEM

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) ______________
- ❏ Other: (specify) ______________
- ❏ 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****

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

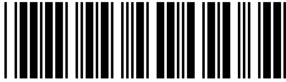
Appointment Policy:

If you are 10 minutes late for your appointment, you are considered to be a "no-show". At this point, we will either, work you into the next available slot or reschedule your appointment for another day. We request adequate notice of appointment cancellation, ideally at least 24 hours. If you are a "no-show" for three appointments, you will be dismissed from the practice.There is a $25 fee for "no-show" appointments and/or less than 24 hour notice cancellations, that may be charged. If charged, you be responsible for the fee, as insurance plans do not cover these charges. You may notify our office of any cancellations by calling during normal business 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.



Consents/Registration
Greenville Health System

GREENVILLE HEALTH SYSTEM (GHS) PATIENT PORTAL ACCESS

A. Patients 16 years old or older or Emancipated Minors

I desire to participate in the Patient Portal. Email address:________________________________

Signature of Patient____Date/Time______________

I authorize proxy access to my Patient Portal to another person. (*if applicable to specific portal*)

Name of Proxy:_______________________________________Relationship:____________________

Email address:____DOB:________________________

Signature of Patient:____Date/Time_________________

B. Patients 12 to 15 years old

My parent/legally authorized representative and I desire to participate in the Patient Portal.

Patient hereby assents to the terms and conditions for participation in the Patient Portal and to allowing a parent (or legally authorized representative) to be granted proxy access.

Patient's email address:____DOB:________________

Signature of Patient____Date/Time_______________

Name of parent/legally authorized representative:____

Email address:_________________________Relationship:____________________DOB:__________

Signature:____Date/Time___________________

C. Patients under 12 years old

I desire to participate in the Patient Portal for my child/ward.

Name of parent/legally authorized representative:__________________________DOB:______________

Email address:_________________________________Relationship:_____________________________

Signature:____Date/Time___________________

D. Patients unable to consent/assent

I desire to participate in the Patient Portal for the above named patient who is unable to consent/assent.

Name of Proxy:_____________________________Relationship to patient:________________________

Email address:____DOB:________________________

Signature:____Date/Time__________________

Appropriate Documentation has been presented to GHS Staff to indicate that the legally authorized representative has authority to sign for the patient.
GHS Staff Signature:___________________________Printed Name:_____________________Date/Time:_____________

*****For new information or updates, please fax to 864-454-2539*****

CHRISTIE PEDIATRIC GROUP NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND RELEASED AND HOW YOU CAN GET THIS INFORMATION. PLEASE READ IT CAREFULLY.

Christie Pediatric Group makes every effort to keep your health information private. Each time you visit Christie Pediatric Group, a record is made. This health or medical record often includes your symptoms, exams and tests, diagnoses, treatment, and care plan. We need this record to give you high-quality care and to meet legal requirements. This Notice applies to all health records produced at Christie Pediatric Group, including those received from other providers. It outlines how we may use and give out information about you for treatment, payment, or healthcare operations, and other purposes granted or required by law. It also describes your rights to get and control your record, and legal requirements we have on its use and release. The law requires Christie Pediatric Group to do the following: (1) Keep your health record private (2) Describe our legal duties and privacy obligations related to your health information (3) Follow the current Notice of Privacy Practices

We reserve the right to change practices and terms of this Notice and the changes will be effective for the information we already have about you and any information we receive in the future. The Notice will list the start date in the top right-hand corner of the first page. Each time you register at Christie Pediatric Group, you may receive a copy of the notice. We will post it in our facilities and on our Web site (www.ghs.org). You may also call our Privacy Office at 864-455-3711 for a copy.

ROUTINE USES AND DISCLOSURES OF YOUR HEALTH RECORD The following sections describe how we use and release medical information. Each section explains what we mean and gives a few examples. (Note: These examples are not all-inclusive.)

Treatment. We use medical information about you to provide, coordinate, and manage your treatment or services. We may give this information to doctors, nurses, technicians, and students of affiliated healthcare programs, volunteers, or other staff who care for you. Various units may share information about you to coordinate your needs, such as lab work or drugs.

We may give details about you to people who are involved in your care, such as a specialist, spouse, or friend. Christie Pediatric Group medical personnel and employees, using their best judgment, may release to a relative, close friend, or other person information about your health related to that person's involvement in your care. Here is how your health record might be used for treatment reasons: We may send your record to specialists our doctors want to consult._(1) Your record may be sent to a doctor to whom you have been referred. (2) You may plan for a friend to pick you up after a procedure. A Christie Pediatric Group representative may believe it is in your best interest to tell your friend what drug you must take that night and what will speed your recovery at home. (3) We may use and release your health record to provide material on treatment options.

Payment. We use and release health information so that treatment and services you receive may be billed to and payment collected from you, an insurance company, or a third party. Here is how your health record might be used for payment purposes. (1) We may call your health plan for pre-approval of a service. (2) We may give your health plan details about your surgery, so it will pay us or reimburse you. (3) If someone else is responsible for your payment, we will contact that person.

Healthcare Operations. We may use and release your record to support our business functions (for example, administrative, financial, and legal activities). These uses and disclosures are needed to run the practice; support treatment and payment, and help patients receive high-quality care. Activities may include measuring quality, reviewing employee performance, and training students. Here is how your health record might be used for business operations. (1) We may call you to confirm your appointment. (2) We may ask you to list your name and your doctor's name when you arrive for a visit. We may also call you by name in a waiting area. (3) We may use health information to review our treatment and services. (4) We may combine information on Christie Pediatric Group patients to decide what services to offer. (5) We may give information to doctors, nurses, technicians, students, and other staff for review and learning purposes. (5) We may combine our records with those from other hospitals or practices to compare how we are doing and where we can improve.

Facility Directory. Unless you object in writing, we include certain facts about you in our directory while you are a patient at Christie Pediatric Group. These facts may include your name, location, and general condition (for example, fair, serious, undetermined).

People Involved in Your Care or Payment for Your Care. Unless you object, Christie Pediatric Group health experts may tell a family member, friend, or other person you identify, or that we have a reasonable basis to believe is involved in your medical care, details about you that relate to that person's involvement in your care. If you cannot physically or mentally agree or object to a disclosure, we may supply information as needed. We may also give information to someone who pays for your care. Finally, we may share facts with someone helping in a disaster relief effort so that family can know of your condition, status, and location.

Business Associates. Business associates of Christie Pediatric Group provide some services related to treatment, payment, and business operations. Examples include medical supplies, transcription, medical record storage, and some aspects of billing. We have a written contract that requires associates to protect your record in the course of performing their job.

SPECIAL USES AND DISCLOSURES OF YOUR HEALTH RECORD

Emergencies. We may use or release your health information during emergencies.

Communication Barriers. We may use or release your record if we try to get your consent but cannot because of major communication barriers and the doctor or staff decides that you intend to consent to use or release such information.

Research. Christie Pediatric Group may release your record for research approved by the Greenville Health System's Institutional Review Committee (IRC). The IRC reviews proposals and protocols to ensure privacy. We may share information about you with researchers starting a project to help them find patients with specific needs (the information will not leave Greenville Health System).

Fundraising Events. We may use your name, address, and dates that you received treatment for Greenville Health System-supported fundraising events. Any fundraising material sent to you will include information telling you what to do to keep from receiving any future communications.

Workers' Compensation. We may release information about you to comply with workers' compensation laws or similar programs.

Legal Proceedings. We may release health information about you for the following reasons: Court or administrative order, and/or subpoena, discovery request, or other lawful process.

Legal Requirements. We will give out medical information about you when required to do so by federal, state, or local law.

Continued on Reverse

Serious Threat to Health or Safety. We may use and release information about you to prevent a serious threat to your health and safety or the health and safety of others.

Health Oversight Activities. We may supply information to a health oversight agency for activities authorized by law, such as audits, investigations, inspections, and licensure. These activities help the government oversee healthcare systems, benefit programs, and civil rights laws.

Public Health Risks. We may release information about you to local, state, or federal public health agencies (such as the Food and Drug Administration and the Department of Health and Environmental Control) for reasons such as: (1) To prevent or control disease, injury, or disability (2) To report births and deaths (3) To report adverse events, product defects or problems, or drug reactions (4) To note product recalls (5) To notify a person who may have been exposed to a disease or may be at risk for getting or spreading one (6) To alert a government agent if we believe a patient is the victim of abuse, neglect, or domestic violence.

Coroners, Funeral Directors, and Organ Donors. We may release information to coroners or medical examiners to identify a deceased person, find cause of death, or carry out duties as required by law. We may also give information to funeral directors to meet their duties and may share such information in the reasonable anticipation of death. We may supply your health record to organ donor groups as approved by you or consistent with the law.

Military, Veterans, and National Security. If you are a member of the armed forces, we may release information about you as required by military authorities. We may also share information about foreign military personnel to the appropriate foreign military authority. We may give information about you to federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Law Enforcement. We may release your health information to a law enforcement official: (1) In response to a court order, subpoena, warrant, summons, or similar legal process (2) To identify or locate a suspect, fugitive, witness, or missing person (3) To provide information about the victim of a crime if, under certain cases, we cannot get the person's agreement or as required by law (4) In case of a death we believe may be the result of criminal conduct (5) In response to criminal conduct at this facility (6) In an emergency to report a crime; the location of the crime or victims; or the identity, description, or location of the person who committed the crime.

Inmates. If you are an inmate of a correctional institution or in custody of a law enforcement official, we may release medical information about you to that facility or person.

YOUR HEALTH INFORMATION RIGHTS

Review and Copy. You have the right to review and request a copy of your health record (this often includes medical and billing records but, under federal law, excludes psychotherapy notes). To do so, write to Christie Pediatric Group, 9 Mills Ave, Greenville, SC 29605. There may be a fee for copying, mailing, and related supplies. We may deny your request to inspect and copy in certain cases. Then you may request a review. Another licensed healthcare professional chosen by Christie Pediatric Group will examine your request. The reviewer will not be the person who denied your request. Christie Pediatric Group will comply with the outcome of the review.

Amend. If you believe that information we have about you is incorrect or incomplete, you may ask us to modify or add the information. You have the right to request a change or addition for as long as Christie Pediatric Group keeps the record. Request your change in writing to Christie Pediatric Group, 9 Mills Ave, Greenville, SC 29605. You must give a reason that supports your request. We may deny your request if it is not in writing or does not include a reason to support the request. We may also deny a request to modify a medical record in these cases: (1) The current information is accurate and complete (2) It is not part of the medical information kept by or for Christie Pediatric Group (3) It is not part of what you would be allowed to view and copy (4) It was not created by us. If we deny this request, you have the right to file a statement of disagreement. We may then prepare a rebuttal. We will give you a copy of the rebuttal.

Accounting of Disclosures. You have the right to request an "accounting of disclosures" (a list of disclosures made about you for reasons other than treatment, payment, Christie Pediatric Group operations, or national security). Request this list by writing to Christie Pediatric Group, 9 Mills Ave, Greenville, SC 29605. Your request must state a period of time, which may not be longer than six years and may not include dates before April 14, 2003. The first list you request within a 12-month period will be free. Additional lists may involve a charge. We will notify you of the cost, and you may cancel or adjust your request before any fees are incurred.

Request Restrictions. You have the right to request that we limit information we use or give out about you for treatment, payment, or healthcare operations. You also have the right to request a limit on what we release to someone involved in your care or payment for your care, such as a family member. For example, you could ask that we not use or give out information about a surgery that you had to your family. ***We are not required to agree to your request.*** If we do agree, we will comply with your request unless the material is needed for emergency treatment. To request restrictions, submit a Restriction of Information Agreement Form to Christie Pediatric Group' registration personnel. State (1) what you want to limit; (2) if you want to limit use, release, or both; and (3) to whom the limits should apply, for example, disclosures to your family.

Request Confidential Communications. You have the right to request that we interact with you about medical matters in a certain way or place. For example, you can ask that we contact you only by mail or only at work. To request confidential communications, submit a Restriction of Information Agreement Form to Christie Pediatric Group' registration personnel. We will try to meet all reasonable requests. You must note how or where you wish to be contacted.

Paper Copy of This Notice. You have the right to a paper copy of this Notice at any time. For a paper copy, call Christie Pediatric Group at 864-242-4840 or the Greenville Health System Privacy Office at 864-455-3711. You may also get a copy from our web site, www.ghs.org

COMPLAINTS If you believe your privacy has been violated, you may file a complaint with Christie Pediatric Group, Greenville Health System or with the Secretary of the Department of Health and Human Services. To file a complaint, call the Practice Manager of Christie Pediatric Group at 864-242-4840, or call our Privacy Office at 864-455-3711 or the GHS Service Excellence Department at 864-455-7975. You may also file an anonymous complaint through our Corporate Compliance Hotline at 1-888-243-3611 (1-800-297-8592 en Espanol). To ensure proper follow-up, complaints must also be submitted in writing.

OTHER USES. Other uses and disclosures of medical information not covered by this notice or relevant laws will be made only with your written consent. If you allow us to use or release health information about you, you may cancel that consent, in writing, at any time. If you revoke it, we will no longer use or release information for the reasons covered by your written consent. **Note:** We cannot take back disclosures already made with your consent.

May 2011