GREENVILLE HEALTH SYSTEM

Patient Information

(Please print)

Full Legal Name: _____ Preferred Name: _____
Last *First* *Middle*

Sex: ☐ Male ☐ Female

Date of Birth: _____ SS#: _____ Ethnicity: Hispanic/Latino ☐
Month/Day/Complete Year 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 _____

Sexual Activity

Are you sexually active? ❑ Yes ❑ No

If you are sexually active, is your partner ❑ Male or ❑ Female?

Do you use birth control? ❑ Yes ❑ No If yes, what method? _____

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:		

PERMISSION TO TREAT - UMG

GENERAL PERMISSION TO TREAT:
I am the Patient named above (or the person authorized by law to make decisions for the Patient). I give permission to Greenville Health System ("GHS") and the physicians, health care providers, staff and outside companies providing services at GHS, to order and provide routine health care services, including diagnostic, laboratory, and treatment procedures, that in the judgment of the provider(s) are necessary to diagnose and treat my symptoms or conditions.

Diagnostic and laboratory procedures that may be ordered for me (and/or my newborn infant) include (but are not limited to) testing for diseases such as Human Immunodeficiency Virus (HIV), Hepatitis, any other diseases categorized as contagious or sexually transmitted diseases, and Methicillin-resistant Staphylococcus Aureus (MRSA). I understand that I can discuss these tests with my health care provider and can tell my health care providers (nurses, technicians and physicians) if I do not want to be tested for any one or all of these diseases. If I do not refuse these tests, I may be tested and those results will be included in my medical record. If the test results are positive, the results will be shared with me. If a health care worker comes in direct contact with my blood or body fluids, I understand that South Carolina law allows my blood to be tested without my consent for the Hepatitis B virus, Hepatitis C virus, or HIV to determine whether or not the viruses are present. The results of the test(s) will be made available to me and to the health care worker who was exposed.

Unless otherwise discussed with me, I authorize GHS to dispose of specimens, tissues, medical devices, or implants removed from my body during my treatment.

HEALTHCARE PROVIDERS: I understand that doctors who are providing services at GHS are members of the GHS medical staff, but they may not be employees or agents of GHS. Some providers, including doctors, physician assistants, nurse practitioners and certified nurse midwives, are non-employed, independent providers. I understand that GHS is not responsible for any act or omission by a provider who is not an employee or agent of GHS. I also understand that GHS is a medical teaching institution and that students and residents may be involved in my care with appropriate required supervision.

TELEMEDICINE: Health care services may be provided via telemedicine which means an image, video recording and/or audio of me may be used to allow health care providers at different locations to see me on a computer screen or view my medical records. Telemedicine may be used for diagnosis, therapy, follow-up and/or education, and may include any of the following: my 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 help protect the confidentiality and integrity of patient identification and imaging data. Prior to use of telemedicine services, a provider will discuss this with the patient.

ASSIGNMENT OF INSURANCE BENEFITS AND THIRD PARTY CLAIMS:
If I have insurance, I agree to assign to GHS any and all rights including money from the following: TRICARE major medical benefits, PIP (personal injury protection), sick benefits, workers' compensation 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 doctors who are 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 pathologists and other private doctors). 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. In the event a claim for payment submitted by GHS to my insurance carrier or plan administrator is denied, I authorize GHS to seek an administrative review of the disputed claim in accordance with the applicable provision(s) of Patients; 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

THIS IS A THREE PAGE DOCUMENT

Initials of Patient/Legally Authorized Representative

CHART COPY

PERMISSION TO TREAT - UMG

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. Such authority shall include the right to request and receive a copy of the plan description and/or summary of the plan description.

MEDICARE PATIENTS: If I am eligible for Medicare coverage, I request that payment of authorized Medicare benefits be made to GHS on my behalf. I certify that the information given by me is correct, in applying for payment under Title XVIII of the Social Security Act.

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 do hereby appoint GHS as my representative to collect the claims, endorse the checks, and give full and final receipt for all amounts collected. In the event benefits exceed the actual charges for this account, I authorize GHS to apply the over payment to any other account(s) for which I am responsible with any entity of GHS, including GHS Partners in Health, Inc., Greenville Health Corporation, and/or any other entity, whether now or later is a part of GHS. If there is no other outstanding accounts 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 debt. 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.

CONTACTING PATIENTS: I give permission to be contacted by GHS and/or GHS Partners in Health, Inc. and its employees and outside contractors including debt collection companies through any contact information that I have provided to GHS and/or GHS Partners in Health, Inc. for any purposes related to my medical diagnosis, treatment, community service, unsolicited advertisements, marketing, payment for services, debt collections for bills owed, or for any other purpose related to treatment, payment or business operations. (This permission to contact also applies to outside independent companies and doctors and their employees who provide services in or for GHS facilities.) I give my permission to GHS contacting me in ways that may cause me to be charged a fee, and I will be responsible to pay the fees related to cell phone, home phone, work phone, text message, email or fax usage for contacts made by GHS. I give permission to GHS using automated dialing and/or artificial or prerecorded voice messages when contacting me by cell, home or work phone, paging service, specialized mobile radio service, radio common carrier service, or by or through any other service for which the called party will be charged a fee for the call or a fee for the data used or a fee for the minutes used for any reason listed above. I give permission to be contacted by SMS text message for appointment reminders. Such notices are unencrypted and are, therefore, considered unsecure communications but they will not include any clinical information. I understand that this permission to contact will allow GHS to call me using phone numbers that I may have listed on National or State Do-Not-Call Registry(s).

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 (NPP). These include providing information to other providers through various methods, including to the GHS Health Information Exchange (HIE), for continuing care, to an insurance company or other payor (such as Medicare) to process payment, and for GHS health care operations such as medical education, peer review and outcomes analysis activities. I acknowledge by signing below that I have had the opportunity to receive a copy of the NPP. I also consent to the following:

- **Mother/Baby Record.** If I am getting care that may affect a baby that I am carrying or have delivered, I consent to any information being put into the baby's medical record, including, but not limited to, psychiatric, drug/alcohol abuse, or any information about testing/treatment for HIV/AIDS, syphilis, communicable, venereal, or other infectious diseases, or my medical history.

THIS IS A THREE PAGE DOCUMENT

Initials of Patient/Legally Authorized Representative

CHART COPY

PERMISSION TO TREAT - UMG

- **Consent to Use and Disclose Sensitive Information.** I specifically consent to any and all of my personal or medical information being used and disclosed to my health care providers and through the HIE as noted in the NPP, including (but not limited to):
    - Information about genetic testing, such as lab tests of my DNA or chromosomes conducted to discover diseases or illnesses of which I am not showing symptoms at the time of the test and that arise solely as a result of defects or abnormalities in genetic material.
    - Information showing (1) whether I have been diagnosed as having AIDS; (2) whether I have been or are currently being treated for AIDS; (3) whether I have been infected with HIV; (4) whether I have submitted to an HIV test; (5) whether an HIV test has produced a positive or negative result; (6) whether I have sought and received counseling regarding AIDS; and (7) whether I have been determined to be a person at risk of being infected with AIDS.
    - Information about suspicion of, diagnosis for, or treatment of mental illness or developmental disability.
    - Information about communicable, venereal, infectious and/or sexually transmitted diseases (ex. HIV/AIDs, Hepatitis, Syphilis, Tuberculosis, Chancroid, Gonorrhea, etc.).
    - Information about pregnancy; prevention of pregnancy (including birth control); child-birth; abortions.
    - Information about diagnosis, treatment, detoxification or rehabilitation for alcohol or drug use or abuse.

PATIENT RIGHTS: I understand that I have certain rights and responsibilities that are set forth in the Patient Rights and Responsibilities that are posted and available as a handout.

PHOTOGRAPHING AND VIDEOTAPING: I understand that GHS may take photographs, video or audio recordings of me only in the course of and for purposes of my treatment, and that GHS will only use any photographs, videos or audio recordings internally for diagnosing, treating or for healthcare operations.

PERSONAL VALUABLES/BELONGINGS: I agree not to bring dangerous items onto GHS property. GHS is NOT responsible for personal property. GHS is a NO SMOKING facility.

Any alterations to the content of any of the conditions above are void and will not change the conditions as stated.

I understand the practice of medicine and the security of personal health information is not an exact science, that not all risks can be eliminated and that no guarantees have been made to me.

I SIGN BELOW ACKNOWLEDGING THAT I HAVE READ, ASKED QUESTIONS AND UNDERSTAND AND AGREE TO ALL 3 PAGES OF THIS FORM.

DATE/TIME	SIGNATURE OF WITNESS	SIGNATURE OF PATIENT/LEGALLY AUTHORIZED REPRESENTATIVE
DATE/TIME	SIGNATURE OF SECOND WITNESS (NECESSARY ONLY FOR TELEPHONE CONSENT)	PRINT NAME AND RELATIONSHIP IF OTHER THAN PATIENT

THIS IS A THREE PAGE DOCUMENT

CHART COPY

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:_____

GREENVILLE HEALTH SYSTEM

Release of Information Authorization

Patient Name: _____ Date of Birth: _____

Last 4 Digits of SSN: _____ Phone #: _____ e-mail address: _____

NOTE: All items, 1 through 6 must be completed, along with signature and date

1.) Release Records To: (**Where** do you want the information sent? **Who** may have the information?)	Name of individual, healthcare provider/hospital/practice: _____ Address: _____ City: _____ State: _____ Zip Code: _____ Day Phone Number: _____ Fax Number: _____		
2.) Obtain Records From: (**Who** has the information you want released?) Please list the specific Hospital and / or clinic.	Name of Hospital Facility or Medical Practice: _____ Address: _____ City: _____ State: _____ Zip Code: _____ Day Phone Number: _____ Fax Number: _____		
3.) Release Instructions: (**How** do you want the information?)	Release Method / Format Requested: (check one) ☐ Mail ☐ My Chart / Epic ☐ Fax (To healthcare provider ONLY) ☐ Electronic ☐ Other _____		
4.) Purpose of Release: (**Why** is it needed?)	☐ Continuing Care ☐ Legal ☐ Patient Request ☐ Military ☐ Insurance ☐ Disability ☐ School ☐ Other _____ I understand that fees for copies of medical records/images and postage fees may be charged as provided by S.C. Law.		
5.) Treatment Date(s): (**When** were you seen?)	☐ Treatment dates from _____ to _____ (please be specific) **OR** ☐ All Treatment Dates		
6.) Information to be Released: (**What** do you want sent or released? Check the appropriate box.)	☐ Abstract Information History & Physical, Consults, Lab & Radiology Reports, Discharge Summary, Operative/ Procedure Reports,. Emergency Department Reports, and Occupational / Physical Therapy Reports.	☐ Immunization Records ☐ Medication List ☐ Physician Progress / Visit Notes ☐ Other: _____	☐ Psychotherapy ☐ Test Results ☐ Demographics

I understand this information may include reference to psychiatric / psychological care, sexual assault, drug abuse, alcohol abuse, and/or results of tests for all infectious diseases including HIV / AIDS.

I understand that I have a right to cancel / revoke this authorization at any time. I understand that if I cancel / revoke this authorization I must do so in writing and present my written cancellation / revocation to the Health Information Services Department (Medical Records). I understand that the cancellation / revocation will not apply to information that has already been released in response to this authorization, as stated in the Notice of Privacy Practice. Unless otherwise canceled / revoked. This authorization will expire / end one year from this date or _____.

I understand that authorizing the disclosure of protected health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to receive treatment. I understand I may review and / or copy the information to be disclosed as provided in 45 CFR 164.524. I understand that any disclosure of information carries with it the possibility of unauthorized disclosure by the person / organization receiving this information. I understand I have a right to a copy of this authorization.

Proof of identity may be required, attaching a copy of your photo ID is recommended. (NOTE: Allow 30 days for processing according to Federal regulation.)

_____ _____

Printed Name of Patient or Legal Guardian / Representative — Date

x_____ _____

Signature of Patient or Legal Guardian Representative — Relationship to Patient, if Signed by Legal Guardian

Document(s) of patient representative's authority must be attached if patient is not signing.

When requesting GHS to send records, return this form to:
255 Enterprise Blvd., Suite 120, Greenville, S.C. 29615; Phone (864) 454-4600 Fax (864) 454-4654

GREENVILLE HEALTH SYSTEM

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.

GHS 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.

GREENVILLE HEALTH SYSTEM

Nondiscrimination Statement

Greenville Health System (GHS) does not discriminate on the basis of race, color, national origin, sex, sexual orientation, gender identity, age or disability in its health programs and activities.

GHS provides appropriate aids and services, including qualified interpreters and written information in various formats, for people with disabilities. GHS provides language assistance services, including translated documents and oral interpretation, to people whose primary language is not English. All services are timely and offered for free. Those needing these services should call (864) 455-7000.

GHS has designated its Diversity Coordinator to ensure compliance with these services. Any person who believes someone has been discriminated against may submit to the Diversity Coordinator, within 60 days of becoming aware of the alleged discrimination, a written complaint with the name and address of the person filing the grievance, as well as the problem or action alleged to be discriminatory.

Complaints may be filed at diversity@ghs.org or 701 Grove Road, Greenville, SC 29605, attn. Diversity Coordinator. Individuals may file a complaint in court or with the U.S. Department of Health and Human Services, Office of Civil Rights, by mail at 200 Independence Ave. SW, Room 509F, HHH Building, Washington, DC 20201, by phone at 1-800-368-1019 or online at https://ocrportal.hhs.gov/ocr/office/file/index.html.

Language Assistance Information

Si usted habla español, tenemos a su disposición servicios gratuitos de asistencia lingüística. Llame al (864) 455-7000. (Spanish)

如果您说中文，傳譯服務可免费提供服务。您可以拨打。(864) 455-7000 (Chinese)

Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số (864) 455-7000. (Vietnamese)

한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. (864) 455-7000 번으로 전화해 주십시오. (Korean)

Si vous ne maitrisez pas bien la langue anglaise, des services gratuits d'assistance linguistique sont disponibles au numero suivant (864) 455-7000. (French)

Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa (864) 455-7000. (Tagalog)

Если Вы говорите на русском языке, то Вам доступны бесплатные услуги переводчика. Звоните (864) 455-7000. (Russian)

Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: (864) 455-7000. (German)

જો તમે ગુજરાતી જાણતા હોય તો, ભાષા સહાયક સેવાઓ, વિના મુલ્યે, તમારા માટે ઉપલબ્ધ છે. ફોન કરો (૮૬૪) ૪૫૫-૭૦૦૦. (Gujarati)

إذا كنت من الناطقين باللغة العربية، تتاح خدمات المساعدة اللغوية لك. اتصل على الرقم 455-7000 (864). (Arabic)

Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para (864) 455-7000. (Portuguese)

注意事項：日本語を話す場合、言語支援サービスは無料でご利用できます。(864) 455-7000 までお電話ください。(Japanese)

Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером (864) 455-7000. (Ukrainian)

अगर आप हिंदी बोलते हैं, तो आप के लिए निः शुल्क भाषा सहायता सेवाएँ उपलब्ध हैं। (864) 455-7000 पर कॉल करें। (Hindi)

បើលោកអ្នកនិយាយភាសាខ្មែរ លោកអ្នកអាចប្រើប្រាស់សេវាជំនួយភាសាបានដោយឥតគិតថ្លៃ។ ហៅទូរសព្ទទៅលេខ (864) 455-7000។ (Cambodian)

Greenville Health System (GHS) makes every effort to keep your health information private. Each time you visit a GHS facility (doctor's office, clinic, hospital or outpatient center), 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 of Privacy Practices* (hereafter referred to as Notice) applies to all health records produced at GHS, 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.

This Notice applies to all GHS sites, including offices of physicians employed by GHS and to all physicians and other healthcare providers who provide you with healthcare services at any GHS site through the Greenville Health System Organized Health Care Arrangement (please see the end of this document for a list of major GHS facilities). It does not apply to care you receive from physicians or other healthcare providers at their private offices (unless the physician or other healthcare provider is employed by GHS) or at any non-GHS site.

The law requires GHS to do the following:

- ***Keep your health record private***
- ***Describe our legal duties and privacy obligations related to your health information***
- ***Follow the current* Notice of Privacy Practices**
- ***Notify you if there is a breach of your unsecured personal health information (PHI)***

We reserve the right to change the practices and terms of this Notice, and the changes will be effective for the information we already have about you as well as any information we receive in the future. The Notice will list the effective date in the top right-hand corner of the first page.

Each time you register at or are admitted to GHS as an inpatient or outpatient, you may have a copy of the Notice. We will post it in our facilities and on our website (**www.ghs.org**). You also may call our Privacy Office at **(864) 797-7755** 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, specialists, technicians, students of affiliated healthcare programs, volunteers or other staff who care for you. Such people may share information about you to coordinate your needs, such as lab work or prescription drugs.

Here is how your health record might be used for treatment reasons:

- A doctor treating your broken leg may need to know if you have diabetes, which slows healing. Also, the doctor may need to tell the dietitian that you have diabetes to arrange for special meals.
- We may send your record to specialists your doctors here may want to consult.
- Your record may be sent to a doctor to whom you have been referred.
- We would share your record with a facility you are being transferred to or one that you are considering transfer to once you leave GHS.
- 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:

- We may call your health plan for pre-approval of a service to determine whether your treatment will be covered.
- We may give your health plan details about your care, so it will pay us or reimburse you. For example, if you have a broken leg, we may need to give your health plan(s) information about your condition and supplies used.
- We may use and disclose your health information to other providers so that they may bill and collect payment for treatment and services they provided to you.
- We may share your health information with billing and collection departments or agencies, insurance companies and health plans to collect payment for services, departments that review the appropriateness of the care provided and the costs associated with that care, and to consumer reporting agencies (for instance, credit bureaus).

Healthcare Operations

We may use and release your record to support our business functions (such as administrative, financial and legal activities). These uses and disclosures are needed to run the hospital, 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 healthcare operations:

- Reviewing and improving the quality, efficiency, and cost of care that we provide to you and other patients
- Evaluating the skills, qualifications, and performance of healthcare providers taking care of you
- Providing training programs for students, trainees, healthcare providers, or non-healthcare professionals (for example, billing clerks) to help them practice or improve their skills

Health Information Exchanges

We will send your health information to any of the Health Information Exchanges (HIEs) that GHS participates in. An HIE is a secure electronic system that helps healthcare providers and entities (such as health plans and insurers) manage care and treat patients. We will send your health information to the Epic Care Everywhere HIE and other HIEs in which we take part.

Information about your past medical care and current medical conditions and medicines is available not only to us but also to non-GHS healthcare providers in the HIE. You have the right to opt out of the HIE. However, even if you do, some of your health information will remain available to certain healthcare entities as permitted by law.

If you have questions or want to opt out of any HIEs, call our Privacy Office at **(864) 797-7755**.

Facility Directory

We may include certain facts about you in our directory while you are a patient at a GHS hospital, clinic or doctor's office. These facts may include your name, location, general condition (such as fair or stable) and religious affiliation. They also may be shared with those who ask for you by name (except for religious affiliation). Your affiliation may be given to clergy members—even if they don't ask for you by name—so family members, friends and clergy can visit you or know how you are doing. However, if you do not want your information listed in the hospital directory, please notify Registration when you arrive or call the facility's Admitting Office.

People Involved in Your Care or Payment for Your Care

We may share your health information with a family member, friend, or other person you identify or who is involved in your care or payment for your care details about you that relate to that person's involvement in your care. However, GHS respects your right to choose not to have your information shared. If you cannot physically or mentally agree or object to a disclosure, we may supply information where necessary. We also 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 GHS provide some services related to treatment, payment and business operations. For example, we may use a copy service to make copies of your medical record. When we hire companies to perform these services, we may disclose your health information to these companies so that they can perform the job we have asked them to do. We have a written agreement 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.

Research

Under certain circumstances, we may use and disclose health information about you for research purposes. All research projects, however, are subject to a special approval process. Before we use or disclose medical information for research, the project will have been approved through this research approval process. We may, however, use health information about you in preparing to conduct a research project, for example, to look for patients with specific needs.

Fundraising Events

GHS is a nonprofit health system that relies on generous support from patients and families to continue vital healthcare, research and education operations. We may use your demographic information such as name, address and birthday to contact you regarding fundraising opportunities. We also may use the dates you received treatment or services, department of service, outcomes information and treating information. You have the right to elect not to receive fundraising communications. Please contact us at **(864) 797-7749** (Office of Philanthropy & Partnership) if you wish to have your name removed from the list to receive fundraising requests supporting GHS in the future. Your decision not to receive fundraising communications will have no impact on your ability to receive healthcare services at any GHS facility.

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
- 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.

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 the following:

- To prevent or control disease, injury or disability
- To report births and deaths
- To report adverse events, product defects or problems, or drug reactions
- To note product recalls
- To notify a person who may have been exposed to a disease or may be at risk for getting or spreading one

To Avert a Serious Threat to Health or Safety and to Report Abuse

We may disclose your health information to a government agent if we believe you have been the victim of abuse, neglect or domestic violence. We also may disclose your information where necessary to protect your health and safety or the health and safety of the public or another person. Disclosures are made only to those people able to help prevent or reduce the threat.

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 also may 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 also may 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:

- In response to a court order, subpoena, warrant, summons or similar legal process
- To identify or locate a suspect, fugitive, witness or missing person
- 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
- In case of a death we believe may be the result of criminal conduct
- In response to criminal conduct at the hospital
- 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 in either an electronic or paper form. This information may include medical and billing records but, under federal law, excludes psychotherapy notes (access to psychotherapy notes is restricted to the treatment team only).

To request a copy of your health record, write to the Medical Records Department of GHS Health Information Management at the address listed on the back cover of this Notice. There may be a fee for costs involving copying, mailing and related supplies. We will respond to you within 30 days of receiving your written request if your record has been maintained in our facility. If your record has been maintained in a secure off-campus location, we will respond within 45 days.

We may deny your request to inspect and copy in certain cases. If we deny your request, we will respond to you in writing, stating why we will not grant your request and describing any rights you may have to request a review of our denial. Another licensed healthcare professional chosen by GHS will examine your request. The reviewer will not be the person who denied your request. GHS 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 to the information. You have the right to request a change or addition for as long as the record is kept by GHS.

Request your change in writing to the Medical Records Department of GHS Health Information Management at the address listed on the back cover of this Notice. You must give a reason that supports your request. To obtain a form to amend, please call the Release of Medical Information Office in Medical Records at **(864) 454-4600**.

We may deny your request if it is not in writing or does not include a reason to support the request. We also may deny a request to modify a medical record in these cases:

- The current information is accurate and complete.
- It is not part of the medical information kept by or for GHS.
- It is not part of what you would be allowed to view and copy.
- 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 and maintain your request to modify in your medical record.

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, healthcare operations or national security). We are required to respond to your request within 60 days.

We are required to provide a listing of all disclosures except the following:

- For your treatment
- For billing and collection of payment for your treatment
- For our healthcare operations
- Occurring as a byproduct of permitted uses and disclosures
- Made to or requested by you or that you authorized
- Made to individuals involved in your care, for directory or notification purposes, or for disaster relief purposes
- Allowed by law when the use and/or disclosure relate to certain specialized government functions or relates to correctional institutions and in other law enforcement custodial situations
- As part of a limited set of information that does not contain certain information which would identify you

The list will include the date of the disclosure, the name (and address, if available) of the person or organization receiving the information, a brief description of the information disclosed and the purpose of the disclosure. Request this list in writing to Medical Information at the appropriate address listed on the back cover of this Notice. Your request must state a period of time, which may not be longer than six years before the date of your request.

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 to your family about a surgery that you had.

You have the right to request that we not disclose to your health plan health information or services for which you paid out of pocket before the performance of those services.

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, obtain a Restriction of Information Agreement Form from an employee at your GHS point of admission or registration. Note (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. Submit the form to the Release of Medical Information Office at the Medical Records address on the back cover of this Notice. We will respond to your request in writing within 30 days.

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 at work.

To request confidential communications, submit a Restriction of Information Agreement Form to an employee at your GHS point of admission or registration. 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 your GHS point of admission or the Privacy Office at **(864) 797-7755**. You also may get a copy from our website, **www.ghs.org**.

Complaints

If you believe your privacy has been violated, you may file a complaint with GHS, with the Secretary of the Department of Health and Human Services or with the South Carolina Department of Health and Environmental Control (DHEC). To file a complaint with GHS, call our Privacy Office at **(864) 797-7755** or Patient & Family Relations at **(864) 455-7975**. To file a complaint with the U.S. Department of Health and Human Services, Office of Civil Rights, send a letter to 200 Independence Ave. SW, Room 509F, HHH Building, Washington, DC 20201; call **1-877-696-6775**; or visit www.hhs.gov/ocr/privacy/hipaa/complaints. To file a complaint with DHEC, send a letter to 2600 Bull St., Columbia, SC 29201; call **1-803-898-3316**; or go to **adacomplaints@dhec.sc.gov**.

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.)*

To request a copy of, review of or amendment to your health record, please write to ...

GHS Health Information Management
Medical Records Department
255 Enterprise Blvd., Ste. 120
Greenville, SC 29615

GHS Major Facilities

Baptist Easley Hospital
200 Fleetwood Drive
Easley, SC 29640

Cottingham Hospice House
390 Keowee School Road
Seneca, SC 29672

Cross Creek Surgery Center
9 Doctors Drive
Greenville, SC 29605

Greenville Memorial Hospital
701 Grove Road
Greenville, SC 29605

Greer Memorial Hospital
830 S. Buncombe Road
Greer, SC 29650

Hillcrest Memorial Hospital
729 S.E. Main St.
Simpsonville, SC 29681

Hospice of the Foothills
390 Keowee School Road
Seneca, SC 29672

Laurens County Memorial Hospital
22725 U.S. Hwy. 76 East
Clinton, SC 29325

Lila Doyle
101 Lila Doyle Drive
Seneca, SC 29672

Marshall I. Pickens Hospital
701 Grove Road
Greenville, SC 29605

Medical Center Clinics
701 Grove Road
Greenville, SC 29605

North Greenville Hospital–Long Term Acute Care
807 N. Main St.
Travelers Rest, SC 29690

Oconee Memorial Hospital
298 Memorial Drive
Seneca, SC 29672

Patewood Memorial Hospital
175 Patewood Drive
Greenville, SC 29615

Roger C. Peace Rehabilitation Hospital
701 Grove Road
Greenville, SC 29605

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