Welcome To Our Practice

We would like to take this opportunity to welcome you to our practice, and look forward to the privilege of meeting your health care needs. Please don't hesitate to let us know at any time if we are not meeting your needs or if you have questions. We have a satisfaction survey that we would like for you to complete after your visit. This will allow us to know how we can better improve our service.

As a member of Oconee Physician Practices and an affiliated health partner with Oconee Medical Center; we are dedicated to providing high quality health care. We are a local non-profit medical group sponsored by the hospital. As a result, any bill you receive from us will have the name of **Oconee Physician Practices** as well as your physician name versus the name of this individual practice location.

For your convenience, you may pay any open balances from other practices affiliated with Oconee Physician Practices at any of our locations.

<u>Please find below a list of all our practices:</u>

Between the Lakes Primary Care
Blue Ridge Women's Center
Clemson-Seneca Pediatrics
Keowee Family Urology
Mountain Lakes ENT and Allergy Center
Mountain Lakes Internal Medicine
Oconee Heart Center
Oconee Kidney Center
Oconee Multi-Specialty Clinic
Rheumatology Consultants
Seneca Medical Associates
Upstate Family Medicine
Upstate Surgical Associates

OCONEE
Physician Practices

Patient Information							
Last Name					Social Sec #		
First Name					Birth Date		
Middle Name					Sex (M or F)		
Street Address					Race		
Suite / Apt #					Primary Language		
City		State		Zip		Marital Status	
Mailing Address					Legal Guardian		
City		State		Zip		Legal Guardian's Primary Phone	
Home Phone		Work Phone				Cell Phone	
Email Address							

Guarantor Information (Person Responsible For Bill)							
Last Name					Social Sec #		
First Name					Birth Date		
Middle Name					Sex (Male or Fem)		
Street Address					Relationship		
City		State		Zip		Home Phone:	
Mailing Address					Work Phone:		
City		State		Zip		Cell Phone:	

Employment Information			
Patient's Employer		Employer Phone	
Spouse's Employer			

Emergency Contact Information					
Name		Relationship		Phone	

Physician Information			
Name of Family Physician		City/State	
Name of Referring Physician		City/State	

Insurance Information For Patient– Provide complete and provide copy of insurance card(s)		
Primary Insurance Company:	Name of Insured:	Relationship to Insured:
	Birthday of Insured:	Their Social Security #:
Secondary Insurance Company:	Name of Insured:	Relationship to Insured:
	Birthday of Insured:	Their Social Security #:
Additional Insurance Company:	Name of Insured:	Relationship to Insured:
	Birthday of Insured:	Their Social Security #:

Assignment of Benefits: I hereby authorize payment of medical benefits directly to Oconee Physician Practices for their services and to release any information acquired in the course of my examination or treatment for insurance purposes. I understand that records may be transmitted electronically or by mail as required.

Signature Of Patient Or Guardian >> _____ **Date:** _____

RHEUMATOLOGY Consultants

Please fill out as much of the following as possible

Patient Name: _____ DOB: _____ SS#: _____

Address: _____

Emergency Contact Name: _____ Phone: _____

Type of employment: _____ Injury job related: **Y N** Date if injury: _____

Referred by: _____ Family Dr: _____

Reason for Referral: _____

Allergies: _____

Preferred Pharmacy_____

Have you received treatment for current problem by any of the following?

Please check all that may apply:

_____ Family Doctor _____ Rheumatologist _____ Chiropractor _____ Podiatrist _____ Orthopedist

Have you recently had any of the following done and if so where? Please check all that may apply:

Blood work: _____ X-Rays: _____ CT-Scan: _____ MRI: _____

Nerve Study: _____ Bone Density: _____

Have you ever taken any of the following medications? Please check all that may apply:

NSAIDS: _____ APAP _____ Ibuprofen _____ Nabumetone _____ Diclofenac _____Celebrex

DMARDS: _____ Prednisone _____ Gold _____ HCQ _____ Methotrexate _____ Remicaid

_____ Enbrel _____ Humira _____ Planqinel

_____ Dairy Products _____ Calcium Supplements _____Vitamin D Supplements

For Women Only:

Have you reached menopause: Y N What age? _____

Length for hormone replacement therapy: _____years

RHEUMATOLOGY Consultants

Personal Medical History-Check all that may apply to you

- ☐ Alzheimer's
- ☐ Anemia
- ☐ Angina pectoris
- ☐ Anxiety
- ☐ Arrhythmia
- ☐ Asthma
- ☐ ADD, inattentive
- ☐ ADHD
- ☐ Back pain w/ radiation
- ☐ Bell's palsy
- ☐ Cancer
- ☐ Carotid artery stenosis
- ☐ Cataract
- ☐ Cerebral palsy
- ☐ Cervical spinal stenosis
- ☐ COPD
- ☐ Chronic fatigue
- ☐ Chronic leukemia
- ☐ Chronic liver disease
- ☐ Cirrhosis
- ☐ Congestive heart failure
- ☐ Coronary art disease
- ☐ Crohn's Disease
- ☐ DVT, leg
- ☐ Depression
- ☐ Diabetes mellitus I
- ☐ Diabetes mellitus II
- ☐ Diverticulosis colon
- ☐ Edema
- ☐ Emphysema
- ☐ Fibrocystic breast disease
- ☐ Fibromyalgia
- ☐ GERD
- ☐ GI bleed
- ☐ Genital Herpes
- ☐ Glaucoma
- ☐ Gout
- ☐ Hepatitis
- ☐ Herpes zoster
- ☐ Hx of phlebitis
- ☐ Hyperlipidemia
- ☐ HTN, essential
- ☐ Hypothyroidism
- ☐ Insomnia
- ☐ Irritable bowel syndrome
- ☐ Memory impairment
- ☐ Mental retardation
- ☐ Migraine
- ☐ Multiple sclerosis
- ☐ MI – heart attack
- ☐ Nephrolithiasis
- ☐ OA (DJD)
- ☐ Osteoporosis
- ☐ Pain, chronic
- ☐ Panic d/o
- ☐ Peptic ulcer
- ☐ Peripheral neuropathy
- ☐ Peripheral vascular disease
- ☐ Pleural effusion
- ☐ Pneumonia
- ☐ Polycystic kidney
- ☐ Prostate specific antigen elevation
- ☐ Prostate hypertrophy (BPH)
- ☐ Renal failure
- ☐ Restless leg syndrome
- ☐ Rheumatic heart disease
- ☐ Rheumatoid arthritis
- ☐ Rosacea
- ☐ Schizophrenia
- ☐ Seizures
- ☐ Sleep apnea
- ☐ Spinal stenosis
- ☐ Spinal stenosis, lumbar
- ☐ Spinal stenosis, thoracic
- ☐ Stroke
- ☐ SLE- Lupus
- ☐ TMJ articular disc d/o
- ☐ TIA-mini strokes
- ☐ Trigeminal neuralgia
- ☐ Tb, pulmonary
- ☐ Ulcerative colitis
- ☐ Walking difficulty

RHEUMATOLOGY Consultants

Past medical procedures- Please check and date all that may apply

Health Maintenance			
☐ Bone Density	☐ Colonoscopy	☐ Mammogram	☐ PAP smear
Eyes, Ear, Nose, Throat and Neck			
☐ Cataract removal ☐ Glaucoma surgery	☐ Laser surgery of eye ☐ Reconstruct cleft palate	☐ Tonsillectomy & Adneoidectomy	☐ Thyroidectomy ☐ Tympanostomy tube
Skin			
☐ Remove skin lesion	☐ Treatment of burn(s)		
Cardiovascular			
☐ CABG ☐ Cardiac Angioplasty ☐ Cardiac surgery	☐ Coronary artery stent ☐ Insertion of heart pacemaker	☐ Repair abdominal aortic aneurysm ☐ Repair arterial blockage	☐ Replace aortic valve ☐ Replace mitral valve
Cardiovascular Diagnostic			
☐ Cardiac cath	☐ Cardiac echo	☐ Cardiac stress test	☐ Holter Monitor
Chest/Lung/Breast			
☐ Breast Lumpectomy	☐ Mastectomy	☐ Remove lung, partial	☐ Treatment of collapsed lung
Chest/Lung/Breast Diagnostic			
☐ Breast biopsy	☐ Chest x-ray	☐ PFT (Spirometry)	☐ PPD
Gastrointestinal			
☐ Appendectomy ☐ Cholecystectomy ☐ Colostomy	☐ Gallbladder Removal ☐ Gastrectomy, partial ☐ Gastric bypass	☐ Hemorrhoidectomy ☐ Hernia Repair ☐ Ileostomy/jejunostomy	☐ Laporoscopic-lap band ☐ Nissen fundoplication Gastric reflux ☐ Splenectomy
Gastrointestinal Diagnostic			
☐ CT Abdomen	☐ EGD	☐ Laparosc diagnostic	☐ Proctosigmoidoscopy

GU/Reproductive			
☐ Abortion, induced	☐ Kidney transplant	☐ Removal of kidney	☐ Tubal sterilization
☐ Dialysis procedure	☐ Prostatectomy	☐ Removal of ovary	☐ Vaginal delivery
☐ Hysterectomy	☐ Prostatectomy (turp)	☐ Remove kidney stone	☐ Vasectomy - ligate
Musculoskeletal			
☐ Amputate leg at thigh	☐ Hip replacement	☐ Remove metatarsal	☐ Treat femoral fracture
☐ Amputation lower leg	☐ Knee replacement	☐ Shoulder surgery	☐ Treat fracture of radius
☐ Amputation of toe	☐ Low back disk surgery	☐ Treat ankle fracture	☐ Treat fracture ulna
☐ Carpal tunnel surgery	☐ Lumbar laminectomy	☐ Treat clavicle fracture	☐ Treat humerus fracture
☐ C-spine disk surgery	☐ Lumbar spine fusion	☐ Treat elbow fracture	☐ Treat lower leg fracture
☐ Fusion of spine	☐ Neck spinal fusion		☐ Treat wrist fracture
Musculoskeletal Diagnostic			
☐ MR Cervical Spine	☐ MR Lumbar Spine	☐ MR Thoracic Spine	
Other Diagnostic			
☐ CT Abdomen	☐ EEG	☐ Motor nerve conduction test	☐ Sleep study, attended
☐ CT Head	☐ Lumbar Puncture		

RHEUMATOLOGY Consultants

Please check any of the following that may apply.
Please write **M**-mother, **F**-father, **G**-grandparent, and **S**- for sibling for whom it may apply to.

Family History - Genetic Risk Factors		
☐ Bleeding d/o _____	☐ DVT _____	☐ Pulmonary embolism _____
☐ CA: Breast _____	☐ Dementia _____	☐ Respiratory d/o _____
☐ CA: Cervical _____	☐ Diabetes mellitus _____	☐ Rheumatoid arthritis _____
☐ CA: Colon _____	☐ Gout _____	☐ Schizophrenia _____
☐ CA: Lung _____	☐ Glaucoma _____	☐ Scleroderma _____
☐ CA: Melanoma _____	☐ Hematological d/o _____	☐ Stroke _____
☐ CA: Other _____	☐ Hypertension _____	☐ Systemic lupus _____
☐ CA: Ovary _____	☐ Migraine _____	☐ Thyroid d/o _____
☐ CA: Prostate _____	☐ Muscle weakness d/o _____	☐ Toxemia _____
☐ CA: Skin _____	☐ Osteoarthritis _____	☐ Tuberculosis _____
☐ CA: Stomach _____	☐ Osteoporosis _____	☐ Vision loss _____
☐ CAD _____	☐ Other inflammatory connective d/o _____	☐ Other arthritic disorder: _____

Social History Please check all that may apply to you.		
☐ Alcohol use Frequency:_____	☐ Substance use Type:_____ Frequency_____	☐ Tobacco use Type:_____ Frequency:_____

Please list all current medication, including over-the-counter and oral contraceptives.

Medication **Dose** **Frequency**

_____
_____
_____
_____
_____
_____
_____
_____
_____

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Physician Practices

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Release of Information Authorization Form

Acknowledgement of Receipt of Notice of Privacy Practices and Financial Policy

This signed form acknowledges that you have received a copy of our practice's Notice of Privacy Practices as required by Federal Law and our Financial Policy. By signing below you are acknowledging that you understand and have read the notices. The notices are yours to keep.

With whom may we discuss patient's financial information?

Patient Only: [ ]

Name: _____ Relationship: _____
For patient over age of 18 only

Name: _____ Relationship: _____
For patient over age of 18 only

May we leave messages regarding appointments?

(Messages regarding any other information will be left as call back request only)

☐ YES _____
What Phone Number

☐ NO

With whom may we discuss patient's medical information?

Patient Only: [ ]

Name: _____ Relationship: _____
For patient over age of 18 only

Name: _____ Relationship: _____
For patient over age of 18 only

_____
Print Patient Name

_____
Patient Date of Birth

_____ _____
Signature of Guarantor/ Patient/ Legal Guardian Date

This authorization is in effect until revoked in writing.

OCONEE
Physician Practices

FINANCIAL POLICY

COLLECTION OF PATIENT AMOUNTS DUE

Insurance companies require that we collect any co-pay or co-insurance amounts at the time of service. We will collect the co-pay amounts at the time of check-in to avoid a wait at check-out. All co-insurance amounts will be collected at the time of check-out. Please understand that you will be responsible for any amounts not paid by your insurance company. OPP also offers a 20% discount to uninsured patients if the balance is paid at the time of service or within 30 days of the visit.

We understand that temporary financial problems may effect timely payment of your balance. We encourage you to communicate any such problems so that we may assist you in the management of your account.

We understand that there may be special agreements between parents regarding a child's medical expenses. However, the parent that brings the child in for a visit is responsible for making payment on that date of service.

PRESCRIPTION REFILL REQUESTS BY PHONE

We will generally need to see an existing patient back in the office prior to calling in a prescription. However, in rare cases where it's appropriate to write the prescription, there will be a $15.00 charge in order to cover operating costs. This is not generally covered by your insurance.

DISMISSAL OF PATIENTS FOR FINANCIAL REASONS

Patients can be dismissed from the practice for a number of reasons, including the following financial situations:

1. Collection Agency Turnover will result in a dismissal from the practice if a patient fails to pay his or her balance within thirty days of turnover.
2. Expedited dismissal occurs when a patient is not honoring his or her financial responsibilities.

All patients should be given at least thirty days notice before being dismissed from practice unless instructed otherwise by physician.

This notice is yours to keep.

301 Memorial Drive, Suite F ● Seneca, SC 29672 ● (864) 885-7989 ● FAX (864) 885-7867