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	REVIEW OF SYSTEMS:					
Check if patient has had any significant problems with the following						
General:	Chest/Heart: murmur chest pain palpitations/heart racing blood pressure problems heart surgery	Hematology/Oncology: anemia prolonged bleeding abnormal bruising history of blood transfusion history of cancer				
Lungs: chronic cough asthma/wheezing recurrent pneumonia apnea	Ear/Nose/Throat: Frequent ear infections Sinus problems Frequent mouth ulcers Swallowing problems Hoarseness	Musculoskeletal: joint pain joint swelling muscle weakness scoliosis cerebral palsy				
Endocrine: growth problem thyroid problem diabetes	Eyes: Usion problems Wears glasses/contacts Eye pain	Skin: Hives Eczema Acne Other				
Bladder: burning or pain with urination urinary incontinence kidney disease urinary tract infection	Neurologic: seizures headaches sensory problems	Allergy/Immunology:				
Females: (if applicable)	Psychological/Developmental: Anxiety Depression Behavior problems Attention deficit/hyperactivity Learning problems Speech delay Motor delay	Other Issues:				



Greenville Health System University Medical Group*

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 University Medical Group or GHS UMG.

<u>Payment for Service</u>: 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.

<u>Completion of medical forms:</u> There may be a charge for completion of forms such as disability, camp physicals, etc.

<u>Copies of Medical Records:</u> There may be a charge for completion of this process; SC Sec. 44-7-325 for Health Care Facilities

- \$.65 per page for the first 30 pages
- \$ 50 per page for all other pages
- Clerical fee not to exceed \$15.00
- Plus actual postage

No-show Appointments: A fee of \$25.00 for a follow up visit and \$50.00 for a new patient visit or endoscopy procedure may be charged for all missed appointments not cancelled at least 24 hours prior to the appointment time. You will be financially responsible for the fee, as insurance plans do not cover these charges. You may notify our office of any cancellations by calling during normal office hours.

<u>Payment for Services Provided by Certain Non-UMG Providers:</u> 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.

<u>Collection Policy:</u> 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.



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.

AUTHORIZATION FOR DISCLOSURE OF MEDICAL INFORMATION Patient Full Name (PRINT) 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 Phone Number Name 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):_____ Date: Time: GHS Representative: Form Create Date: December 30, 2013