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:**_____

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.

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, online at https://ocrportal.hhs.gov/ocr/office/file/index.html or by phone at 1-800-368-1019.

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)