

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，傳譯服務可免費提供服務。您可以撥打。(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 (864) 455-7000. (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)

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.

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 \$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.

Payment for Services Provided by Certain Non-UMG 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 864-885-7989 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.



Patient Information

(Please print)

Full Legal Name: Last First Middle Preferred Name: Sex: Male Female Date of Birth: Month/Day/Complete Year SS#: Ethnicity: Hispanic/Latino Non-Hispanic/Non-Latino Refuse/Decline Primary Care Physician: Preferred Pharmacy Name: Phone Number: Marital Status: Single Married Divorced Widowed Life Partner Legally Separated Race: Caucasian (white) American Indian African American (black) Hispanic Biracial Asian Oriental Other Unknown Home Address: City: State: Zip: Mail to Address: City: State: Zip: County: Home Phone: Cell Phone: Preferred language: E-mail: Veteran: Yes No Unknown Religion:

Guarantor Information (If guarantor is Self, skip to Emergency Contact)

Parent/guardian presenting minor child for treatment will be listed as the guarantor. If 18 or older, patient will be listed as guarantor and does not have to complete this section. The guarantor will be responsible for any balance due.

Name: Last First Middle Patient relation to Guarantor: Home Phone: Cell Phone: Date of Birth: SS#: City: State: Zip: Country: 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: Cell Phone: Patient Relation to Emergency Contact: Secondary Contact Name: Home Phone: Cell Phone: Patient Relation to Emergency Contact:

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: Last First Middle Nickname: Date of Birth: Month / Day / Complete Year SS#: Home Address: City: State: Zip: 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: Last First Middle Nickname: Date of Birth: Month / Day / Complete Year SS#: Home Address: City: State: Zip: 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

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: _____

Date _____

Mountain Lakes ENT, Allergy & Hearing Center

Daniel Boxwell, DO

Drew Collins, MD

Ron Gooden, Au. D

Patient Name _____ DOB _____
Pharmacy Name _____ Pharmacy Location _____

Medical History (Do you/the patient have any of the following?)

Activity change	Y N	Eye redness	Y N	Skin color change	Y N	Weight
Appetite change	Y N	Visual disturbance	Y N	Rash	Y N	
Chills	Y N	Tinnitus	Y N	Environmental allergies	Y N	Height
Fatigue	Y N	Trouble swallowing	Y N	Food allergies	Y N	
Fever	Y N	Voice change	Y N	Dizziness/headaches	Y N	
Weight change	Y N	Apnea	Y N	Light headedness	Y N	
Congestion	Y N	Chest tightness	Y N	Numbness	Y N	
Drooling	Y N	Choking	Y N	Seizures	Y N	
Ear discharge	Y N	Cough	Y N	Speech difficulty	Y N	
Ear pain	Y N	Shortness of breath	Y N	Tremors	Y N	
Facial swelling	Y N	Wheezing	Y N	Weakness	Y N	
Hearing loss	Y N	Chest pain	Y N	Behavior problem	Y N	
Mouth sores	Y N	Leg swelling	Y N	Confusion	Y N	
Nosebleeds	Y N	Palpitations	Y N	Hallucinations	Y N	
PND/Rhinorrhea	Y N	Abdominal pain	Y N	Hyperactive/nervous	Y N	
Sinus pressure	Y N	Constipation	Y N	Sleep disturbance	Y N	
Sneezing	Y N	Diarrhea	Y N	Suicidal ideas	Y N	
Sore throat	Y N	Nausea/vomiting	Y N			
Eye itching	Y N	Cold/heat intolerance	Y N			

What complaint brings you in today? _____
All surgical procedures? _____

Are you allergic to any medications (please list what type of reaction you had)

<u>Medication</u>	<u>Reaction</u>
_____	_____
_____	_____
_____	_____
_____	_____

Please list all medications you are currently taking (we can make a copy if you have a list with you)

<u>Drug</u>	<u>Reason for taking</u>
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Do you take Aspirin, ibuprofen or any blood thinners? Y N

Social History

Do you use tobacco?	Y N	Do you consume alcohol?	Y N
Cigarettes (how many/day)	_____	# of Beers per week	_____
Cigars (how many/day)	_____	# of glasses of wine per week	_____
Chew tobacco?	Y N	# of drinks of hard liquor per week	_____
Have you ever smoked?	Y N	History of drug abuse?	Y N
How long did you smoke?	_____	History of HIV/AIDS risk factors?	Y N
Loud noise exposure?	Y N	Fallen within past 12 months?	Y N

Family History (Immediate family only and relation)

Heart disease	Y N	Relative(s):	_____
Early onset hearing loss	Y N	Relative(s):	_____
High blood pressure	Y N	Relative(s):	_____
Bleeding disorder	Y N	Relative(s):	_____
Stroke	Y N	Relative(s):	_____
Cancer	Y N	Relative(s):	_____
Diabetes	Y N	Relative(s):	_____
Asthma	Y N	Relative(s):	_____

Are there any other significant disease that run in your family?

Radiology

Have you had an x-ray, MRI or CAT Scan of your head or neck in the past year? Y N
 If YES, when and at what facility? _____

Audiology

Have you had a hearing test in the past year? Y N
 If YES, when at what facility? _____

Complete for minor patients only - Social History

Are patient's immunizations up to date?	Y N
Are there smokers in the home?	Y N
Is the patient a product of a normal pregnancy and delivery?	Y N
Is the patient exposed to tobacco smoke?	Y N
Are there brothers and/or sisters in the home?	Y N
Does the patient attend daycare or school?	Y N
Are there pets in the home?	Y N
**If yes what kind?	



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)

DOB _____

MRN _____

Authorization for Disclosure of Medical Information: The privacy of your medical information is important. We will discuss your medical condition with person(s) you designate.

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHOM? (Check and complete one)

The following family members or other individuals may receive information regarding my medical condition:
Print first and last name(s) _____

OR

Any family member or other individual inquiring about my medical condition may receive information from my provider, EXCEPT the following individuals: *Print first and last name(s)* _____

You may revoke/cancel or modify/change the above designation, but the revocation or modification must be in writing.

NOTE: This designation does not give the above named individuals the right to make health care decisions for you. If at any time you are unable to consent to care or treatment, we will follow the procedure set forth in the South Carolina Adult Health Care Consent Act.

Confidential Communication: Please provide phone number(s) where we can reach you:

Home: _____ Work: _____ Cell Phone: _____ Other: _____

Messages: A request for return calls may be left on the following answering machine or voice mail: (Check all that apply)

Home Work Cell Phone I do not authorize

I authorize my medical information to be left on the following answering machine or voice mail: (Check all that apply)

Home Work Cell Phone I do not authorize

If we are unable to reach you or leave a message at the above phone number(s), please indicate with whom we may leave a message for you to call our facility.

Name _____ Phone Number _____

Name _____ Phone Number _____

Note: An automated appointment reminder system may call the number listed in our data base.

Signature: I hereby authorize the disclosure of my medical condition and information as described above.

Patient/Patient's Representative Signature: _____ Date: _____ Time: _____

PRINT Name (if Patient's Representative): _____

Relationship to Patient (if Patient's Representative): _____

GHS Representative: _____ Date: _____ Time: _____

Form Create Date: December 30, 2013



CONSENT AND AUTHORIZATION - UMG

The following are conditions for services provided by the Greenville Health System (GHS) for the above-named patient :

CONSENT AND AUTHORIZATION FOR ROUTINE TREATMENT: I consent to and authorize GHS and my health care providers to provide or order routine health care services, including diagnostic and laboratory procedures that in the judgment of my provider(s), are necessary. Unless otherwise discussed with me, I authorize GHS to dispose of specimens, tissues, medical devices, or implants removed from my body during my treatment. Diagnostic/laboratory procedures that may be ordered could include testing for HIV, Hepatitis, and other diseases categorized as sexually transmissible diseases. I can tell my provider if I do not want to be tested for any and all of these diseases. If test results are positive, they will be shared with me.

PHYSICIANS: I understand that physicians who are members of the GHS medical staff and who practice in GHS facilities may not be employees or agents of GHS. I understand that GHS is not responsible for any act or omission by a physician who is not an employee or agent of GHS. I understand GHS is a medical teaching institution and that students and residents may be involved in my care with required/appropriate supervision.

TELEMEDICINE: Health care services may be provided via telemedicine which involves the use of electronic communications to enable health care providers at different locations to share individual patient medical information for the purpose of improving patient care. The information may be used for diagnosis, therapy, follow-up and/or education, and may include any of the following: Patient 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 protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption

ASSIGNMENT OF INSURANCE BENEFITS AND THIRD PARTY CLAIMS: If my account is not paid at the time of my visit, I hereby assign to GHS any and all rights, including proceeds, I may have from the following: TRICARE major medical benefits, PIP (personal injury protection), sick 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 physician(s) 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 anesthesiologists, pathologists, and other private physicians). 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. I understand that I am responsible for any charges not covered by insurance, including Medicare, Medicaid, or any other benefits. In the event a claim for payment submitted by GHS to my insurance carrier or plan administrator is denied, I hereby authorize GHS to seek an administrative review of the disputed claim in accordance with the applicable provision(s) of my 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 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, including Medicare and Medicaid. Such authority shall include the right to request and receive a copy and/or summary of the plan description.

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 hereby appoint GHS as my representative to collect the claims, endorse the checks, and give full and final receipt for all amounts collected. If the benefits received by GHS exceed the charges on my account, I authorize GHS to apply the over-payment to my other outstanding account(s) with GHS or GHS entities, which include GHS Partners in Health, Inc., Greenville Health Corporation, and/or any other entity that is or becomes a part of GHS. If there is no other outstanding account 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 account. 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.

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

CONTACTING PATIENTS: I hereby authorize GHS to contact me through the information provided at the time of registration. I hereby consent to receive autodialed and/or pre-recorded calls regarding my outstanding balance, if any, from or on behalf of GHS and/or GHS Partners in Health, Inc. at the telephone number(s) that I have provided to GHS and/or GHS Partners in Health, Inc.

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. These include providing my information to other providers for my continuing care, to an insurance company or other payor (such as Medicare) to process payment for my care, and for GHS health care operations such as medical education, peer review and outcomes analysis activities. I understand that my personal and health information will be made available to providers through the GHS Health Information Exchange as described in the Notice of Privacy Practice. I acknowledge by signing below that I have received a copy of the GHS Notice of Privacy Practices.

HEALTHCARE ASSOCIATED INFECTIONS: Healthcare-associated infections can be a complication of hospitalization. South Carolina has a public reporting law: Hospital Infections Disclosure Act, S.C. code Ann. Section 44-7-2410, which requires hospitals to monitor and report targeted healthcare associated infections to the Department of Health and Environmental Control (DHEC). These reports are available on the following website for public view: <http://www.scdhec.gov/Health/FHPF/InfectionControl/HIDA/HospitalInfectionControl/>

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CONSENTS/REGISTRATION



CONSENT AND AUTHORIZATION - UMG

PHOTOGRAPHING: I consent to GHS taking photographs for purposes of identification, diagnosis, treatment, education, and research. Photographs that could identify me will be used only for internal medical record identification purposes unless I specifically agree and sign an additional consent document.

CONDITIONS FOR CARE; ALTERATIONS VOID: I understand that the above are conditions for care and treatment at GHS. Any alterations to the content of any of the conditions above are void and will not change the conditions as stated. I understand that by signing this form, or receiving care or treatment at GHS, I agree to the contents of this Consent and Authorization in its "as is" form.

SIGNATURE OF PATIENT/LEGALLY AUTHORIZED REPRESENTATIVE _____

PRINTED NAME AND RELATIONSHIP IF OTHER THAN PATIENT _____

DATE _____ TIME _____

SIGNATURE OF WITNESS _____ DATE _____ TIME _____

SIGNATURE OF WITNESS _____ DATE _____ TIME _____
(SECOND WITNESS FOR TELEPHONE CONSENT OR SIGNATURE WITH "X" OR MARK)