PRISMA HEALTH®

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 ☐ 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 Prisma Health for services rendered. I will be responsible for any amount not covered by my insurance.

Signature of Patient/Guardian/Guarantor: _____ **Date:**_____

PRISMA HEALTH®

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 _____

PRISMA HEALTH®

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		

PRISMA HEALTH®

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:		

PRISMA HEALTH®

Disclosure Med Info
Prisma Health-Upstate

Authorization for Disclosure of Medical Information

Patient Full Name (PRINT) _____ 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)*

☐ **YES -** The provider may discuss my medical condition with the following family member or other individual:

_____

_____

☐ **NO** The provider may not discuss my medical condition with any family member or other individual.

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.

Communication: Please provide phone number(s) where we can reach you (by providing a number you also authorize Prisma Health to leave you voicemails at the number(s) listed):

☐ Home: _____ ☐ Cell: _____ ☐ Work: _____

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

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

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

PRINT Name (if Patient's Representative): _____

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

Prisma Health Representative: _____Date: _____Time:____

PRISMA HEALTH®

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 Organization/Hospital 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 the date of signature unless otherwise specified.

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.)

Be aware the processing of this document will release the entire medical record requested which may include information from other providers.

_____ _____

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

PRISMA HEALTH®

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 Prisma Health and the various entities and providers affiliated with them each individually and collectively referred to as Prisma Health.

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 Prisma Health.

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.