

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: _____
SS#: _____ Month / Day / Complete Year
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: _____
SS#: _____ Month / Day / Complete Year
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
				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: _____



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 _____

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
<input type="checkbox"/> Tetanus	_____	_____	_____
<input type="checkbox"/> Flu	_____	_____	_____
<input type="checkbox"/> Pneumonia	_____	_____	_____
<input type="checkbox"/> HPV	_____	_____	_____
<input type="checkbox"/> 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	_____	_____
	_____	_____
	_____	_____
	_____	_____

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
<input type="checkbox"/> High Blood Pressure	_____	_____
<input type="checkbox"/> High Cholesterol	_____	_____
<input type="checkbox"/> Heart Disease	_____	_____
<input type="checkbox"/> Stroke	_____	_____
<input type="checkbox"/> Migraines	_____	_____
<input type="checkbox"/> Seizures/Convulsions	_____	_____
<input type="checkbox"/> Diabetes	_____	_____
<input type="checkbox"/> Bleeding/Blood-clotting Disorder	_____	_____
<input type="checkbox"/> Allergies	_____	_____
<input type="checkbox"/> Asthma	_____	_____
<input type="checkbox"/> Thyroid Problems	_____	_____
<input type="checkbox"/> Osteoporosis	_____	_____
<input type="checkbox"/> Psychiatric Disorder/Mental Illness	_____	_____
<input type="checkbox"/> Alzheimer's/Dementia	_____	_____
<input type="checkbox"/> Cancer - type:	_____	_____
<input type="checkbox"/> Other:	_____	_____

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 Prisma Health and the physicians, health care providers, staff and outside companies providing services at Prisma Health, 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 Prisma Health 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 Prisma Health are members of the Prisma Health medical staff, but they may not be employees or agents of Prisma Health. Some providers, including doctors, physician assistants, nurse practitioners and certified nurse midwives, are non-employed, independent providers. I understand that Prisma Health is not responsible for any act or omission by a provider who is not an employee or agent of Prisma Health. I also understand that Prisma Health 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 Prisma Health 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 Prisma Health), 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 Prisma Health, 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 Prisma Health (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 Prisma Health to my insurance carrier or plan administrator is denied, I authorize Prisma Health 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 Prisma Health as my authorized representative and grant to Prisma Health 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 Prisma Health 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 Prisma Health, 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 Prisma Health 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 Prisma Health to apply the over payment to any other account(s) for which I am responsible with any entity of Prisma Health, including Greenville Health Corporation, and/or any other entity, whether now or later is a part of Prisma Health. If there are 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 Prisma Health 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 Prisma Health and its employees and outside contractors including debt collection companies through any contact information that I have provided to Prisma Health 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 Prisma Health facilities.) I give my permission to Prisma Health 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 Prisma Health. I give permission to Prisma Health 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 Prisma Health 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 Prisma Health Notice of Privacy Practices (NPP). These include providing information to other providers through various methods, including to the Prisma Health, Health Information Exchange (HIE), for continuing care, to an insurance company or other payor (such as Medicare) to process payment, and for Prisma Health 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.

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Initials of Patient/Legally Authorized Representative

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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 Prisma Health may take photographs, video or audio recordings of me only in the course of and for purposes of my treatment, and that Prisma Health will only use any photographs, videos or audio recordings internally for diagnosing, treating or for health care operations.

PERSONAL VALUABLES/BELONGINGS: I agree not to bring dangerous items onto Prisma Health property. Prisma Health is NOT responsible for personal property. Prisma Health 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

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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: _____

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) <input type="checkbox"/> Mail <input type="checkbox"/> My Chart / Epic <input type="checkbox"/> Fax (To healthcare provider ONLY) <input type="checkbox"/> Electronic <input type="checkbox"/> Other _____		
4.) Purpose of Release: (Why is it needed?)	<input type="checkbox"/> Continuing Care <input type="checkbox"/> Legal <input type="checkbox"/> Patient Request <input type="checkbox"/> Military <input type="checkbox"/> Insurance <input type="checkbox"/> Disability <input type="checkbox"/> School <input type="checkbox"/> 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?)	<input type="checkbox"/> Treatment dates from _____ to _____ (please be specific) OR <input type="checkbox"/> All Treatment Dates		
6.) Information to be Released: (What do you want sent or released? Check the appropriate box.)	<input type="checkbox"/> Abstract Information History & Physical, Consults, Lab & Radiology Reports, Discharge Summary, Operative/ Procedure Reports, Emergency Department Reports, and Occupational / Physical Therapy Reports.	<input type="checkbox"/> Immunization Records <input type="checkbox"/> Medication List <input type="checkbox"/> Physician Progress / Visit Notes <input type="checkbox"/> Other: _____	<input type="checkbox"/> Psychotherapy <input type="checkbox"/> Test Results <input type="checkbox"/> Demographics
<p>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.</p> <p>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.</p> <p>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.</p> <p>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.)</p> <p>Be aware the processing of this document will release the entire medical record requested which may include information from other providers.</p>			

 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

When requesting Medical Imaging from Prisma Health to send images, return this form to:

301 East 1st Avenue, Easley, S.C. 29640; Phone (864) 522-1867 Fax (864) 522-1895



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 Prisma Health 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.