

**PATIENT INFORMATION**

*(Please print)*

Full Legal Name: \_\_\_\_\_ Preferred Name: \_\_\_\_\_  
Last First Middle

Date of Birth: \_\_\_\_\_ SS#: \_\_\_\_\_ Sex:  Male  Female  
Month/Day/Complete Year

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: \_\_\_\_\_ Primary Phone: (\_\_\_\_) \_\_\_\_\_ Secondary Phone: (\_\_\_\_) \_\_\_\_\_

Preferred language: \_\_\_\_\_ E-mail: \_\_\_\_\_

Veteran:  Yes  No  Unknown Religion: \_\_\_\_\_

**GUARANTOR INFORMATION (If guarantor is SELF complete SECTION I only)**

*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 balances due.*

Name: \_\_\_\_\_ Patient relation to Guarantor : \_\_\_\_\_  
Last First Middle

Date of Birth \_\_\_\_\_ SS#: \_\_\_\_\_ Primary Phone: (\_\_\_\_) \_\_\_\_\_  
 Secondary Phone: (\_\_\_\_) \_\_\_\_\_

Home Address: \_\_\_\_\_ (City) (State) (Zip) (Country)

Mail to Address \_\_\_\_\_ (City) (State) (Zip) (Country)  
*(if different):*

**EMERGENCY CONTACT (Pediatric Patients please list someone other than parent(s)/guardian)**

Primary Contact  
 Name: \_\_\_\_\_ Primary Phone: (\_\_\_\_) \_\_\_\_\_  
 Patient Relation to Emergency Contact : \_\_\_\_\_  
 Second Phone: (\_\_\_\_) \_\_\_\_\_

Secondary  
 Contact Name: \_\_\_\_\_ Primary Phone: (\_\_\_\_) \_\_\_\_\_  
 Patient Relation to Emergency Contact : \_\_\_\_\_  
 Second Phone: (\_\_\_\_) \_\_\_\_\_

**SECTION I**

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  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

SS#: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Month / Day / Complete Year

Home Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
*(if different from patient)*

Primary Phone: \_\_\_\_\_ Secondary 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

SS#: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Month / Day / Complete Year

Home Address: \_\_\_\_\_ (City) (State) (Zip)  
*(if different from patient)*

Primary Phone: \_\_\_\_\_ Secondary 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. Skip to SECTION IV**

**ACCIDENT INFORMATION**

Is visit result of an accident? (Examples: auto accident, workers compensation, etc.)  YES  NO

Type of accident: \_\_\_\_\_ Date of Accident: \_\_\_\_\_ County of accident: \_\_\_\_\_

**PRIMARY INSURANCE INFORMATION (If subscriber is SELF complete SECTION II only)**

**SUBSCRIBER INFORMATION (This is the person who carries the insurance)**

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: \_\_\_\_\_ Primary Phone: ( ) \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_ Ext: \_\_\_\_\_

**SECTION II**

Insurance Co. Name: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

Group No: \_\_\_\_\_ CERT# \_\_\_\_\_ Effective Date: \_\_\_\_\_

Subscriber Status:  full-time  part-time  self employed  active military  student full time  
 student part-time  retired  disabled  not employed

**SECONDARY INSURANCE INFORMATION (If subscriber is SELF complete SECTION III only)**

**SUBSCRIBER INFORMATION (This is the person who carries the insurance)**

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: \_\_\_\_\_ Primary Phone: ( ) \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_ Ext: \_\_\_\_\_

**SECTION III**

Insurance Co. Name: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

Group No: \_\_\_\_\_ CERT# \_\_\_\_\_ Effective Date: \_\_\_\_\_

Subscriber Status:  full-time  part-time  self employed  active military  student full time  
 student part-time  retired  disabled  not employed

**SECTION IV**

**AUTHORIZATION**

*I authorize medical evaluation & treatment, and release of information for insurance/medical purpose concerning my illness and treatment. I hereby authorize payment from my insurance company to the Greenville Hospital System for services rendered. I will be responsible for any amount not covered by my insurance.*

Signature of Patient/Guardian/Guarantor: \_\_\_\_\_

Date: \_\_\_\_\_



**CONSENT FOR TREATMENT**

The following are the conditions for services provided by the Greenville Hospital System (GHS) for the patient whose name appears above.

**MEDICAL AND SURGICAL CONSENT:** Physicians who are members of the Medical Staff who practice in GHS facilities may not be employees or agents of GHS; therefore, GHS is not responsible for any act or omission by a physician who is not an employee or agent of GHS. GHS is a medical teaching institution; therefore, medical students and residents may be involved in your care under the supervision of an attending physician. I/We consent to any x-ray examination, laboratory procedure, anesthesia, medical, surgical or services given the patient under the general and special instructions of the physician. If a health care worker comes in direct contact with a patient's blood or body fluids, I/We understand that the patient's blood may be tested for the hepatitis B virus, hepatitis C virus, or the HIV (human immunodeficiency virus) to determine whether or not the viruses are present, endangering the health care worker (in accordance with South Carolina State Statute title 44, chapter 29, section 44-29-230). The results of the testing will be made available to the patient.

**ASSIGNMENT OF INSURANCE BENEFITS AND THIRD PARTY CLAIMS:** If the account is not paid at time of discharge, I hereby assign to GHS any and all rights including proceeds 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 relating to the patient, whether insured or self-funded, proceeds of any liability settlement or judgement being paid by or on behalf of a third party, or any other benefits due from the insurance policy. All amounts collected will be applied to the patient's account. I understand that I am responsible for any charges not covered by insurance, Medicare, Medicaid, or any other benefits. I hereby also assign to any physician 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 Radiologists, Pathologists, Emergency Department Physicians, and other private physicians.] In addition, I/We further warrant and represent that any insurance or any plan which we assign is valid insurance and in effect and that I/We have the right to make this assignment. 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. Section 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. Section 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 plan description.

**THIS IS A TWO PAGE DOCUMENT**

Initials of Patient/Legally Authorized Representative



## HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record. Please answer to the best of your ability.

Date: \_\_\_\_\_

Name: _____	Preferred Name: _____	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Date of Birth: _____	Age: _____	Height: _____
Occupation: _____		Employer: _____
Hobbies: _____		School (if applicable): _____
What is your hand dominance: <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Ambidextrous		
Who requested that you visit our office: <input type="checkbox"/> Doctor (Please provide full name): _____		
<input type="checkbox"/> Athletic Trainer:	<input type="checkbox"/> Friend:	<input type="checkbox"/> Other: _____
<input type="checkbox"/> ER: _____ <input type="checkbox"/> Self Referred		
Primary Care Physician (if different from above): _____		
<b>Current Medications / Dosages:</b> _____ _____ _____		
<b>Medical History</b> (check all that apply): <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Heart Disease <input type="checkbox"/> Stroke <input type="checkbox"/> Emphysema <input type="checkbox"/> Diabetes <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Hypothyroidism <input type="checkbox"/> Hyperthyroidism <input type="checkbox"/> Cancer; type _____ <input type="checkbox"/> Osteoporosis/Osteopenia <input type="checkbox"/> Hepatitis; type _____ <input type="checkbox"/> Other: _____ <input type="checkbox"/> None		
<b>Drug Allergies:</b> <input type="checkbox"/> None	Reaction: _____	
_____	<input type="checkbox"/> Rash <input type="checkbox"/> Anaphylaxis <input type="checkbox"/> Stomach Upset <input type="checkbox"/> Hives <input type="checkbox"/> Dizziness	
_____	<input type="checkbox"/> Rash <input type="checkbox"/> Anaphylaxis <input type="checkbox"/> Stomach Upset <input type="checkbox"/> Hives <input type="checkbox"/> Dizziness	
_____	<input type="checkbox"/> Rash <input type="checkbox"/> Anaphylaxis <input type="checkbox"/> Stomach Upset <input type="checkbox"/> Hives <input type="checkbox"/> Dizziness	
_____	<input type="checkbox"/> Rash <input type="checkbox"/> Anaphylaxis <input type="checkbox"/> Stomach Upset <input type="checkbox"/> Hives <input type="checkbox"/> Dizziness	
<b>Past Surgical History:</b>	<i>Type of Surgery</i>	<i>Date of Surgery</i>
_____	_____	<i>Full name of Surgeon</i>
_____	_____	_____
<b>Family History</b> (check all that apply): <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Heart Disease <input type="checkbox"/> Diabetes <input type="checkbox"/> Emphysema <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Stroke <input type="checkbox"/> Cancer <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Other: _____ <input type="checkbox"/> None		
<b>Social History</b> (check all that apply): <input type="checkbox"/> Tobacco Use ; Type _____ Frequency _____ How long _____ <input type="checkbox"/> Alcohol Use ; Type _____ Frequency _____ <input type="checkbox"/> Drug Use ; Type _____ Frequency _____ <input type="checkbox"/> None		
<b>REVIEW OF SYSTEMS</b>		
<b>Constitutional:</b> <input type="checkbox"/> Fever <input type="checkbox"/> Weight Loss <input type="checkbox"/> Weight Gain <input type="checkbox"/> Fatigue <input type="checkbox"/> Chills <input type="checkbox"/> Night Sweats		
<b>Cardiovascular:</b> <input type="checkbox"/> Chest Pain <input type="checkbox"/> Irregular Heart Beat <input type="checkbox"/> Poor Circulation <input type="checkbox"/> Leg/Foot Swelling <input type="checkbox"/> Leg/Foot Ulcer		
<b>Genitourinary:</b> <input type="checkbox"/> Blood in Urine <input type="checkbox"/> Painful Urination <input type="checkbox"/> Unable to Urinate <input type="checkbox"/> Difficulty Urinating <input type="checkbox"/> Frequent Urination <input type="checkbox"/> Bladder Infection		
<b>Neurological:</b> <input type="checkbox"/> Paralysis <input type="checkbox"/> Frequent Headaches <input type="checkbox"/> Seizures <input type="checkbox"/> Stroke/CVA/ITA <input type="checkbox"/> Dizziness <input type="checkbox"/> Tremors <input type="checkbox"/> Speech Problems <input type="checkbox"/> Anxiety/Depression <input type="checkbox"/> Feelings of Hopelessness <input type="checkbox"/> Sleep Disturbance <input type="checkbox"/> Vision Changes		
<b>Eyes:</b> <input type="checkbox"/> Decreased Vision <input type="checkbox"/> Cataracts		
<b>Respiratory:</b> <input type="checkbox"/> COPD <input type="checkbox"/> Asthma <input type="checkbox"/> Persistent Cough <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Wheezing <input type="checkbox"/> Pneumonia		
<b>ENT:</b> <input type="checkbox"/> Loss of Hearing <input type="checkbox"/> Sinusitis <input type="checkbox"/> Headache		
<b>Gastrointestinal:</b> <input type="checkbox"/> GERD <input type="checkbox"/> PUD/Gastritis <input type="checkbox"/> Liver Problems <input type="checkbox"/> Stomach Pain <input type="checkbox"/> Diarrhea <input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Nausea/Vomiting <input type="checkbox"/> Black tar-like/bloody stool		
<b>Skin:</b> <input type="checkbox"/> Rash <input type="checkbox"/> Dryness of Skin <input type="checkbox"/> Skin Ulcers/Open Sores <input type="checkbox"/> Skin Cancer/New Moles <input type="checkbox"/> Poor Healing <input type="checkbox"/> Skin Infection		
<b>Psychiatric:</b> <input type="checkbox"/> Depression/Anxiety <input type="checkbox"/> Bipolar Disease		
<b>Endocrine:</b> <input type="checkbox"/> Diabetes <input type="checkbox"/> Hypothyroidism <input type="checkbox"/> Hyperthyroidism <input type="checkbox"/> Heat Intolerance <input type="checkbox"/> Cold Intolerance		
<b>Heme/Lymph:</b> <input type="checkbox"/> Anemia <input type="checkbox"/> Bleeding Problems <input type="checkbox"/> Blood Transfusions <input type="checkbox"/> Bruising		
<b>Allergic/Immunologic:</b> <input type="checkbox"/> Seasonal <input type="checkbox"/> Iodine <input type="checkbox"/> Food Allergies (please list) : _____		
<b>Musculoskeletal:</b> <input type="checkbox"/> Joint Swelling <input type="checkbox"/> Muscle Aches <input type="checkbox"/> Joint Pain <input type="checkbox"/> Pain in Multiple Joints <input type="checkbox"/> Weakness		

Physician' Initial: \_\_\_\_\_ Date: \_\_\_\_\_

Name: \_\_\_\_\_

DOB: \_\_\_\_\_

**PAIN AND PROBLEM QUESTIONNAIRE**

DATE \_\_\_\_\_

What is the main reason for your office visit today (chief complaint):  Right  Left

Have you had any of the following (pertaining to this problem)?  MRI  X-rays  CT  Other \_\_\_\_\_

When did your symptoms first appear? \_\_\_\_\_

How long has this problem been present? \_\_\_\_\_ Days \_\_\_\_\_ Weeks \_\_\_\_\_ Months \_\_\_\_\_ Years

How did this begin:  Gradual  Suddenly  After Injury  No Known Mechanism of Injury  
 Work-Related  Work-Injury  Motor Vehicle Crash

Please provide date of injury or accident: \_\_\_\_\_

Describe injury or accident: \_\_\_\_\_

Circle the number that describes your pain **right now**? (for the specific problem you are being seen for today)



No pain      0   1   2   3   4   5   6   7   8   9   10      Pain as bad as you can imagine

My pain is  Not satisfactorily controlled       Satisfactorily controlled

The pain feels (quality):  Sharp  Stabbing  Dull  Aching  Burning  Throbbing  
 Other:

The pain is (duration):  Constant       Comes and Goes (Intermittent)

Does your pain move anywhere?  No  Yes; where?

Are there any associated symptoms?  Swelling  Numbness  Tingling  Weakness  Stiffness  
 Locking  Catching  Giving Away  Other:

Since your problem started, it is:  Getting Better  Getting Worse  Unchanged

What makes your symptoms better?  Rest  Heat  Ice  Elevation  Medication (see below)  
 Other:

What makes your symptoms worse?  Activity  Exercise  Work  Kneeling  Bending  Squatting  
 Stooping  Stairs  Hills  Running  Walking  Prolonged Sitting  Other:

Does your pain or problem interfere with any of the following (check all that apply):  General Activity  Sports  
 Normal Work  Mood  Enjoyment of life  Ability to concentrate  Relationship with others  
 Other (Explain):

Please check if you are having any of the following?

- Fever/chills  Unexpected Weight Loss  Rashes  Night pain  Recent Trauma
- Problems with bowel or bladder function  Groin Numbness  Recent bacterial infection
- Suppressed Immune System  Intravenous drug use  Pain with coughing or sneezing

**Please answer the following questions if you are a post-menopausal woman, or a man over age 65.**

- 1. Have you ever had a bone density test?  Yes  No
- 2. Has someone in your family ever broken a hip or been told they have osteoporosis?  Yes  No
- 3. Is your diet low in calcium (avoid milk, cheese, yogurt, lactose intolerant)?  Yes  No
- 4. Do you have frequent/chronic diarrhea (Gluten intolerance, malabsorption)?  Yes  No
- 5. Do you weigh less than 125 pounds?  Yes  No
- 6. Have you fallen down 2 or more times in the last year?  Yes  No
- 7. Do you have rheumatoid arthritis?  Yes  No
- 8. Have you taken steroids (Cortisone, Prednisone) for 3 or more months in your life?  Yes  No
- 9. Have you been treated for cancer with chemotherapy or other medication?  Yes  No
- 10. Do you take medication for epilepsy or a seizure disorder?  Yes  No
- 11. Do you currently smoke?  Yes  No
- 12. Do you drink 3 or more alcoholic drinks per day?  Yes  No
- 13. Do you drink 3 or more caffeinated drinks (coffee, tea, soda) per day?  Yes  No
- 14. Have you broken any bones (after the age of 50)?  Yes  No
- 15. Do you walk or jog for exercise?  Yes  No

Physician' Initial: \_\_\_\_\_ Date: \_\_\_\_\_



### DISCLOSURE OF MEDICAL INFORMATION

**Disclosure of Medical Information:** Your medical information and communication of that information is essential to your care. We prefer to speak directly with each patient but we understand that other individuals or family members may have knowledge of and be assisting in your care. Please list the individuals who we are authorized to discuss your care with. (NOTE: We can not discuss your care with others, including spouses or other family members living with you, unless they are listed below.)

<u>Name of Person</u>	<u>Relationship to Patient</u>
_____	_____
_____	_____

**Confidential Communication:** Communication between this practice and you, the patient, is critical to your health. Please list the phone number(s) where we can reach you.

<input type="checkbox"/> Home: _____	<input type="checkbox"/> Work: _____
<input type="checkbox"/> Cell phone: _____	<input type="checkbox"/> Other: _____

If we are unsuccessful at reaching you at the above phone numbers, please list others who we can contact to get a message to you to call our office. *An automated appointment reminder system will call your home number listed in our data base.*

<u>Name of Person</u>	<u>Phone Number</u>	<u>Relationship to Patient</u>
_____	_____	_____
_____	_____	_____

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

At home     At work     On my cell phone     I do not authorize

I authorize any medical information regarding myself to be left on the following answering machine or voice mail (*Check all that apply*)     At home     At work     On my cell phone     I do not authorize

**Signatures:** I hereby authorize the use or disclosure of the personal health information as described above.

Patient/Personal Representative Signature: \_\_\_\_\_ Date: \_\_\_\_\_

PRINT Name of Personal Representative: \_\_\_\_\_

Relationship of Representative to Patient: \_\_\_\_\_

GHS UMG Representative: \_\_\_\_\_ Date: \_\_\_\_\_

**Note:** This restriction applies only to care provided by the Greenville Hospital System University Medical Group practice identified in the upper left hand corner of this form. Other providers involved in your treatment may require you to complete a separate request for restriction. Either you or UMG may terminate this restriction by completing the following. **The below signature is to be used if you would like to make the above information terminate on a certain date.**

This agreement is terminated as of \_\_\_\_\_ Signature \_\_\_\_\_ (Date) \_\_\_\_\_

Patient Full Name (PRINT) \_\_\_\_\_ DOB \_\_\_\_\_



**FINANCIAL POLICY**

Patient Full Name (PRINT) \_\_\_\_\_ DOB \_\_\_\_\_

**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 by Greenville Hospital System, GHS Partners in Health, and the various entities and providers affiliated with them each individually and collectively referred to as Greenville Hospital System University Medical Group or GHS UMG for the patient whose name appears above.

**Payment for Service:** Our office will inform you of the amount due when you check out. This amount is 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 the number listed above 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 Hospital 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.

**Signatures:** I have read and understand these financial policies.

Patient/Personal Representative Signature: \_\_\_\_\_ Date: \_\_\_\_\_

PRINT Name of Personal Representative: \_\_\_\_\_

Relationship of Representative to Patient: \_\_\_\_\_

GHS UMG Representative: \_\_\_\_\_ Date: \_\_\_\_\_



STEADMAN HAWKINS  
CLINIC of The CAROLINAS



ORTHOPAEDIC  
RESEARCH FOUNDATION  
of the Carolinas

## **Steadman Hawkins Clinic of the Carolinas Orthopaedic Surgery and Sports Medicine Fellowship Program Disclosure Statement**

During your visit today you may be examined by a physician who is participating in the Steadman Hawkins Clinic of the Carolinas Fellowship Program. We have both an Orthopaedic Sports Medicine Fellowship Program and a Nonoperative/Primary Care Sports Medicine Fellowship Program. The programs are accredited one year fellowships in which fully trained orthopaedic surgeons and primary care physicians are chosen from the top medical schools and residency programs across the country to do an additional year of study to focus on shoulder and knee reconstruction and sports medicine. Annually, a group of six physicians are chosen from over 100 applicants to participate in the Orthopaedic Surgery Fellowship Program and two physicians for the Primary Care Sports Medicine Fellowship.

In working with patients, the Fellows will introduce themselves and state that they will be working closely with the consulting doctor in your ongoing care. A plan of treatment is suggested by the Fellow and finalized by the supervising surgeon or physician. In the operating room the fellow will meet with the patient along with the consulting surgeon preoperatively, see patients after surgery with the consulting surgeon on rounds, and may participate in surgical procedures in the operating room.

A Fellow's role in surgery is under the direct supervision of one of our surgeons who is present at all cases. All patient interaction is done under close supervision of the Steadman Hawkins Clinic physicians. We are also part of the Greenville Hospital System Orthopaedic Residency Program. Residents are medical doctors in training to become orthopaedic surgeons. They may be involved in your care as well and will perform his/her role under supervision.

Having trained over 150 surgeons world wide, we are proud of our fellowship program. It is one of the best in the country and the only ACGME Accredited Orthopaedic Sports Medicine Fellowship in South Carolina. It is important for our patients and the community to know that this situation provides the best possible medical care for you with a large talented team involved in your care.

Please feel free to ask the Fellow or the consulting physician any questions you might have regarding the Steadman Hawkins Clinic of the Carolinas Fellowship Programs.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date of birth

\_\_\_\_\_  
Date