Patient Registration Form

Carolina Health Centers Inc.

Account #_____

Name on File with Insurance:_____ Patient's DOB:_____

Preferred Name:_____ Suffix:_____ Patient's SSN:_____

Patient's Address:_____

Patient's City, State, Zip:_____

Patient's Home/Cell Phone:_____ Patient's Work/Other Phone:_____

Emergency Contact Information

Name:_____ Phone #:_____

Address:_____

City, State,Zip:_____

Relationship to Patient:_____

Please keep in mind this person may be contacted if we can not reach you directly for appointment reminders, lab results, or referral appointments.

Primary Care Provider

Provider:_____

Preferred Pharmacy

Name:_____

Mail Order Pharmacy

Name:_____

Demographics

Please select one box from each of the following sections. The following information is for demographic purposes only and will not affect your care.

Employment Status

- ☐ Full Time
- ☐ Part Time
- ☐ Unemployed
- ☐ Student

Marital Status

- ☐ Single
- ☐ Married
- ☐ Partnered
- ☐ Divorced
- ☐ Separated
- ☐ Widowed

Sexual Orientation

- ☐ Lesbian or Gay
- ☐ Straight
- ☐ Bisexual
- ☐ Something Else
- ☐ Don't Know
- ☐ Chose not to disclose

Additional

- ☐ Veteran
- ☐ Homeless
- ☐ Migrant Work
- ☐ Seasonal Worker

Gender at Birth

- ☐ Male
- ☐ Female

Ethnicity

- ☐ Hispanic/Latino
- ☐ Non-Hispanic/Latino

Race

- ☐ Black African American
- ☐ Asian
- ☐ American Indian/Alaskan Native
- ☐ Native Hawaiian/Pacific Islande
- ☐ White

Gender Identity

- ☐ Male
- ☐ Female
- ☐ Transgender Male (female to male)
- ☐ Transgender Female (male to female)
- ☐ Other
- ☐ Chose not to disclose

Signature:_____ Date:_____

Patient Financial Information

Account #_____

Sliding Fee Scale Information

We are required to charge for all services. However, charges may be adjusted according to your income and the number of family members. Are you interested in applying for sliding fee at this time?

☐YES I would like an application ☐NO Not at this time

Income Information

Annual Income:_____

How many people (including yourself) are supported by the annual income:_____

Insurance Information

- ☐ Medicare
- ☐ Medicaid
- ☐ United Healthcare
- ☐ Blue Cross Blue Shield
- ☐ Blue Choice
- ☐ Cigna
- ☐ Other:_____

Responsible Party Information

Name:_____

Phone #:_____

Address:_____

City, State, Zip:_____

Policy 1:_____

Effective Date:_____

Card Holders Sex:____Male ____Female

Card Holders Birthdate:_____

Copay Amount $_____

Policy 2:_____

Effective Date:_____

Card Holders Sex:____Male ____Female

Card Holders Birthdate:_____

Copay Amount $_____

Carolina Health Centers is committed to providing health care to all patients, regardless of ability to pay. We accept Medicaid, Medicare and most private insurance plans. We offer a Sliding Fee Scale based on income and family size. We also have a prompt payment discount available to patients who do not have insurance and do not qualify for the sliding fee scale when payment in full is made on the date service is provided.

Carolina Health Centers bills both primary and secondary insurance for your charges. All co-pays are due on the date service is provided. If you do not pay your co-pay at the time of service, payment will be required before appointments are scheduled. We can refer you to our billing office to establish a payment plan if you are not able to make payment in full.

Although we file insurance claims, payment for your medical services is your responsibility and you will be billed for any claims that are not paid by your insurance plan.

Payment options:

We accept cash, checks, credit and debit cards and money orders.

Past Due Accounts

A monthly payment is required on all accounts with an outstanding balance. If you have not made a payment on your account in the last 30 days, some payment will be required before another appointment is scheduled. Our billing department can council you in such cases. Accounts with balances over 120 days will be turned over to a collection agency. After an account has been turned over to a collection agency, payment will be required prior to your appointment and a payment plan must be established and followed.

By Signing below, I agree to be responsible for all the fees that are not paid by insurance. I authorize Carolina Health Centers, Inc. to release ay medical information necessary to process my insurance claims and I authorize assignment of benefits and/or payments directly to Carolina Health Centers, Inc.

Signature:_____ Date:_____

Carolina Health Centers Inc.

ePrescribing Consent

ePrescribing is a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy from the point of care. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. ePrescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an ePrescribe program. These include:

- **Formulary and benefit transactions** – Gives the prescriber information about which drugs are covered by the drug benefit plan.
- **Medication history transactions** – Provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.
- **Fill status notification** – Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription has been picked up, not picked up, or partially filled.

By signing this consent form, you are agreeing that Carolina Health Centers can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes. In other words, you are giving us permission to view your prescription medication history so that we may better serve you by sending your prescriptions to the pharmacy electronically. We will be able to view any medications that have been prescribed to you in the past as well as information about whether or not you have gotten a prescription filled.

Understanding all of the above, I hereby provide informed consent to Carolina Health Centers to enroll me in the ePrescribe program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

Print Patient Name:_____ Patient DOB:_____

Signature of Patient or Guardian:_____ Date: _____

Relationship to Patient: _____

HEALTH HISTORY/REVIEW OF SYSTEMS

NAME: _____ AGE:_____DATE:_____ CHART#:_____

Primary Care Provider: _____

Hospitalizations _____

And Surgeries: _____

_____

Medical Problems: _____

_____

Medications: _____

_____

Allergies: _____

MEDICAL SYMPTOMS: CIRCLE ALL THAT APPLY

General	Use of Tobacco (past or present), Alcohol, Caffeine, or Drugs; Chills; Dizziness; Fainting; Fever; Sweats; History of Cancer; Weight Change; Recurrent Headaches; Anemia; Transfusions; Exposure or Risk of AIDS; Any Exercise? Yes/No Last Tetanus Booster: _____Last Pneumovax: _____
Eyes	Crossed Eyes; Double Vision; Pain; Blurred Vision; Glaucoma; Red Eyes
Ears	Earache; Discharge; Loss of Hearing; Ringing in Ears
Nose/Throat	Nosebleeds; Thyroid Problems; Sinus Trouble; Hay Fever; Hoarseness; Teeth or Gum Problems
Cardiovascular	Chest Pain; High Blood Pressure; Irregular Heart Beat; Poor Circulation; Murmur; Heart Attacks; Heart Disease; Shortness of Breath; High Cholesterol
Respiratory	Chronic Cough; Asthma; Emphysema; Coughing up Blood; Pneumonia; Wheezing; Night Sweats
Gastrointestinal	Poor Appetite; Bowel Changes; Constipation; Diarrhea; Nausea; Ulcers; Rectal Bleeding; Liver Disease; Jaundice; Hepatitis; Gallbladder Disease; Hemorrhoids; Blood in Stools; Dark or Black Stools
Genitourinary	Blood in Urine; Painful Urination; Difficult Urination; Prostate Problems; Kidney Stones; Venereal Disease; Sexual Difficulties
Musculoskeletal	Arthritis; Gout; Fractures; Chronic Back Pain; Injuries
Neurologic	Confusion; Head Injury; Numbness; Seizures; Fainting; Stroke; Dizziness
Psychiatric	Anxiety; Depression; Drug Addiction; Suicide Attempt; Sleeping Difficulties; Marital Problems
Endocrine	Diabetes; Lethargy or Fatigue; Heat or Cold Intolerance; Thyroid Disease
Skin Diseases	Dry Skin; Skin Cancers; Sores that Don't Heal; Changing Moles
Gynecological (females only)	Last Pap Smear:_____Last Mammogram;_____# of Pregnancies:_____# of Births:_____ Birth Control Method: None – Pill – Condoms – Diaphragm – Rhythm – IUD – Shots – Tubal – Vasectomy-Other Irregular of Painful Periods; Bleeding Between Periods or after Sex
Family History	Circle Illnesses that Parents or Siblings Have or Have Had: Diabetes; Heart Disease; Hypertension or High Blood Pressure; Cancer; Alcohol Abuse; Strokes; Asthma; Depression; Tuberculosis, Glaucoma

Other Comments

_____ _____

Provider Signature DATE

Carolina Health Centers Inc.

How Did You Hear About Carolina Health Centers?

(Please Check One of the Following)

- o Family Member, Friend, or Co-Worker
- o Newspaper
- o Telephone Book
- o Health Fair or Other Community Event
- o Radio
- o Other: _____

_____

_____

Carolina Health Centers Inc.

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions concerning this notice, you may contact the Privacy Officer for Carolina Health Centers, Inc. at 864-388-0301 or write us at 313 Main St., Greenwood, SC 29646.

This Notice of Privacy Practice is provided to you as a requirement of the Health Insurance Portability and Accountability Act (HIPAA). It describes how we may use or disclose your protected health information, with whom that information may be shared, and the safeguards we have in place to protect it. This notice also describes your rights to access or refuse the release of specific information outside our system except when the release is required or authorized by law or regulations.

ACKNOWLEDGMENT OF RECEIPT OF THIS NOTICE

You will be asked to provide a signed acknowledgment of receipt of this notice. Our intent is to make you aware of the possible uses and disclosures of your protected health information and your privacy rights. If you decline to provide a signed acknowledgment, we may continue to provide your treatment, and will use and disclose your protected health information for treatment, payment, and health care operations when necessary.

WHO WILL FOLLOW THIS NOTICE

This notice describes the information privacy practices followed by our employees, staff, and other office personnel. The practices described in this notice will also be followed by all of our health care providers who will have access to your personal health information.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU.

For Treatment We may use health information about you to provide you with medical treatment or services. We may disclose health information about you to doctors, nurses, technicians, office staff or other personnel who are involved in taking care of you and your health.

For example, your doctor may be treating you for a condition and may need to know if you have other health problems that could complicate your treatment. The doctor may use your medical history to decide what treatment is best for you. The doctor may also tell another doctor about your condition so that doctor can help determine the most appropriate care for

you.

Different personnel in our office may share information about you and disclose information to people who do not work in our office in order to coordinate your care, such as phoning in prescriptions to your pharmacy, scheduling lab work and ordering x-rays. Family members and other health care providers may be part of your medical care outside this office and may require information about you that we have.

To further facilitate your health care, we are exchanging medical information with other doctors, nurses, technicians, office staff or other personnel who are involved in taking care of you and your health through an electronic Health Information Exchange called Lakelands Connect. Lakelands Connect provides a quicker, more efficient way to obtain your medical information in order to provide high quality health care to you. In addition, Lakelands Connect provides extensive security and privacy for your medical information.

For payment We may disclose health information about you so that treatment and services you receive at this office may be billed to and payment may be collected from you, an insurance company, or a third party. For example, we may need to give your health plan information about a service you received here so your health plan will pay us or reimburse you for the service. We may also tell your health plan about a treatment you are going to receive to obtain prior approval, or to determine whether your plan will cover the treatment.

For Health Care Operations We may use and disclose health information about you in order to run the office and make sure that you and our other patients receive quality care. For example, we may use your health information to evaluate the performance of our staff in caring for you. We may also use health information about all or many of our patients to help us decide what additional services we should offer, how we can become more efficient, or whether certain new treatments are effective.

Appointment Reminders/Messages We may contact you as a reminder that you have an appointment for treatment or medical care at the office. We will also leave messages for call backs as needed on your telephone or with a family member.

Treatment Alternatives We may tell you about or recommend possible treatment options or alternatives that may be of interest to you.

Health-Related Products and Services We may tell you about health-related products or services that may be of interest to you.

Please notify us if you do not wish to be contacted for appointment reminders, or if you do not wish to receive communications about treatment alternatives or health-related products or services. If you advise us in writing (at the address listed at the top of this Notice) that you do not wish to receive such communications, we will not use or disclose your information for these purposes.

You may revoke your Consent at any time by giving us written notice. Your revocation will be effective when we receive it, but it will not apply to any uses and disclosures which occurred before that time.

If you do revoke your Consent, we will not be permitted to use or disclose information for purposes of treatment, payment or health care operations, and we may therefore choose to discontinue providing you with health care treatment and services.

Your protected health information is secure through our fax machine. We also shred protected health care information before we dispose of it. All test notifications will be sent out to you in secure envelopes.

Business Associates There are some services provided in our organization through contracts with business associates. An example is a copy service that makes copies of your health record. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do and bill you, your insurance company or third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.

Future Communications We may communicate to you via newsletters, mail outs or other means regarding treatment options, health related information, disease-management programs, wellness programs, or other community based initiatives or activities our facility is participating in. When disclosing information regarding appointment reminders and billing/collections efforts, we may leave a message on your answering machine or voice mail.

SPECIAL SITUATIONS

We may use or disclose health information about you without your permission for the following purposes, subject to all applicable legal requirements and limitations:

To Avert a Serious Threat to Health or Safety We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Required by Law We will disclose health information about you when required to do so by federal, state or local law.

Public Health Risks We may disclose health information about you for public health reasons in order to prevent or control disease, injury, or disability, or report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products.

Coroners, Medical Examiners and Funeral Directors We may release health information to a Coroner or Medical Examiner. This may be necessary, for example, to identify a deceased

person or determine the cause of death.

Family and Friends We may disclose health information about you to your family members or friends if we obtain your verbal agreement to do so or if we give you an opportunity to object to such a disclosure and you do not raise an objection. We may also disclose health information to your family or friends if we can infer from the circumstances, based on our professional judgment that you would not object. For example, we may assume you agree to our disclosure of your personal health information to your spouse when you bring your spouse with you into the exam room during treatment or while treatment is discussed.

In situations where you are not capable of giving consent (because you are not present or due to your incapacity or medical emergency), we may, using our professional judgment, determine that a disclosure to your family member or friend is in your best interest. In that situation, we will disclose only health information relevant to the person's involvement in your care. For example, we may inform the person who accompanied you to the emergency room that you suffered a heart attack and provide updates on your progress and prognosis. We may also use our professional judgment and experience to make reasonable inferences that it is in your best interest to allow another person to act on your behalf to pick up, for example, filled prescriptions, medical supplies, or x-rays.

OTHER USES AND DISCLOSURES OF HEALTH INFORMATION

We will not use or disclose your health information for any purpose other than those identified in the previous sections without your specific, written authorization. We must obtain your authorization separate from any consent we may have obtained from you. If you give us authorization to use or disclose health information about you, you may revoke that authorization in writing, at any time. If you revoke your authorization, we will not longer use or disclose information about you for the reasons covered by your written authorization, but we cannot take back any uses or disclosures already made with your permission.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

You have the following rights regarding health information we maintain about you:

Right to Inspect and Copy You have the right to inspect and copy your health information, such as medical and billing records, that we use to make decisions about your care. You must submit a written request to the Privacy Officer in order to inspect and/or copy your health information. If you request a copy of the information, we will charge a fee for the costs of copying, mailing or other associated supplies. We may deny your request to inspect and/or copy in certain limited circumstances. If you are denied access to your health information, you may ask that the denial be reviewed. If such a review is required by law, we will select a licensed health care professional to review your request and our denial. The person conducting the review will not be the person who denied your request and we will comply with

the outcome of the review.

Right to Amend If you believe health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment as long as the information is kept by this office.

To request an amendment, complete and submit a Medical Record Amendment/Correction Form to the Privacy Officer. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

a) we did not create, unless the person or entity that created the information is no longer available to make the amendment;
b) it is not part of the health information that we keep;
c) you would not be permitted to inspect and copy;
d) it is accurate and complete.

Right to an Accounting of Disclosures You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you for purposes other than treatment, payment and health care operations. To obtain this list, you must submit your request in writing to the Privacy Officer. It must state a time period, which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper, electronically). We may charge you for the costs of providing this list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for it, like a family member or friend. For example you could ask that we not use or disclose information about a surgery you had.

We Are Not Required to Agree to Your Request If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

To request restrictions, you may complete and submit the Request for Restriction on Use/Disclosure Of Medical Information to the Privacy Office.

Right to Request Confidential Communications You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For

example, you can ask that we only contact you at work, or by mail.

To request confidential communications, you may complete and submit the Request for Restriction On use/Disclosure of Medical Information And/Or Confidential Communication to the Privacy Officer. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

CHANGES TO THIS NOTICE

We reserve the right to change this notice, and to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a summary of the current notice in the office with its effective date in the top right hand corner. Your are entitled to a copy of the notice currently in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. That number is 1-800-368-1019. To file a complaint with our office, contact the Privacy Officer for Carolina Health Centers, Inc. at 864-388-0301. You will not be penalized for filing a complaint.

Acknowledgement of Receipt of Privacy Notice

For office use only:

Patient Name: _____
Medical Record #:_____
Date of Acknowledgement: _____

By signing this form, you acknowledge that Carolina Health Centers, Inc. has given you a copy of its Privacy Notice, which explains how your health information will be handled in various situations.

Check all that are true:

[ ] **I have received Carolina Health Centers, Inc. Privacy Notice.**

[ ] **Carolina Health Centers, Inc. has given me the chance to discuss my concerns and questions about the privacy of my health information.**

[ ] **I choose to disclose my information to the following individuals:**

_____ _____
_____ _____

_____
Patient's Signature

Carolina Health Centers, Inc. staff should complete is Acknowledgement Form is not signed:

1. Does patient have a copy of the Privacy Notice? [ ] Yes [ ] No

2. Please explain why the patient was unable to sign an acknowledgement form and Carolina Health Centers, Inc. efforts trying to obtain the patient's signature:

_____
_____
_____
_____

Carolina Health Centers Inc.

SLIDING FEE VERIFICATION FORM

NAME (First, Middle, Last)	RELATION TO YOU	Date of Birth	ADDRESS	AMOUNT OF INCOME	VERIFIED

DO YOU OR DOES ANYONE IN YOUR HOUSEHOLD RECEIVE ANY OF THE FOLLOWING?
PLEASE CHECK ALL ITEMS.

	YES	NO	AMOUNT
FINANCIAL ASSISTANCE FROM DSS (AFDC, GEN. DISABILITYASSISST., GEN. ASSISTANCE FOR INELIGIBLE SPOUSE, OPTIONAL OR MANDATORY SUPPLEMENT)			
SUPPLEMENTAL SECURITY INCOME (SSI)			
SOCIAL SECURITY INCOME			
VETERANS ADMINISTRATION BENEFITS (VA)			
OTHER PENSION AND RETIREMENT INCOME, RAILROAD RETIREMENT			
WORKMAN'S COMP./UNEMPLOYMENT COMP., STRIKE BENEFITS			
TRAINING STIPEND (BOARD, FOOD)			
CHILD SUPPORT AND ALIMONY			
MONEY FROM RELATIVES OR FRIENDS			
INTEREST, DIVIDENDS, OR TRUST INCOME			
OTHER (SPECIFY)			
PAYMENTS FROM INSURANCE CO.			
PAYMENTS FROM BOARDERS/RENTERS			

NUMBER OF FAMILY MEMBERS_____ APPLICANT'S ESTIMATED INCOME_____
VERIFIED INCOME_____ALLOWABLE CREDIT_____
UPDATE INTERVAL_____
NOTES:_____

I HEREBY AUTHORIZE CAROLINA HEALTH CENTERS TO VERIFY ALL OF THE INFORMATION GIVEN ABOVE. I UNDERSTAND THAT IF THERE IS ANY INCORRECT OR MISLEADING INFORMATION I WILL BE TERMINATED FROM THE DISCOUNT PROGRAM AND WILL BE REQUIRED TO PAY FULL FEES.

I AGREE TO PROVIDE DOCUMENTATION AS PROOF OF MY ELIGIBILITY WITHIN 7 DAYS. BY FAILING TO DO SO, I WILL BE RESPONSIBLE FOR THE FULL FEE. I UNDERSTAND THAT THIS DISCOUNT EXPIRES ONE YEAR FROM TODAY AND THAT I MUST REAPPLY IN ONE YEAR TO CONTINUE TO RECEIVE THIS DISCOUNT.

_____ _____ _____
Signature of Patient Signature of Interviewer Date