



Christie Pediatric Group

Patient Registration Packet

Please fill out the attached forms as completely as possible and bring them with you to your visit. PLEASE – DO NOT FAX THIS PACKET.

We care about your child's total health and knowing the medical history can help us provide the best care for child's needs.

Thank you for your time and patience. Let us know if you have any questions.

Doctors Offices at:
9 Mills Ave, Greenville, SC 29605
3911 S. Hwy 14, Greenville, SC 29615
1409 W. Georgia Rd, Suite A, Simpsonville, SC 29680

Visit our websites at:
www.ghschildrens.org/christieped
www.christiepediatricgroup.com



PATIENT INFORMATION (Please print)

Full Legal Name: _____ Preferred Name: _____
Last First Middle

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

Primary Care Physician: _____ Ethnicity: Hispanic/Latino
 Non-Hispanic/Non-Latino
 Refused/Declined

Preferred Pharmacy Name: _____ Phone Number: _____

Marital Status: Single Married Divorced Widowed Life Partner Legally Separated

Race: Caucasian (white) American Indian African American (black) Hispanic
 Biracial Asian Oriental Other Unknown

Home Address: _____ City _____ State _____ Zip _____
 Mail to Address: _____ City _____ State _____ Zip _____

County: _____ 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 balance 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 (if different): _____ (City) _____ (State) _____ (Zip) _____ (Country) _____

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 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

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 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 (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: (____) _____

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 (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: (____) _____

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

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: _____

GHS UNIVERSITY MEDICAL GROUP

MEDICATIONS, ALLERGIES AND IMMUNIZATIONS

PRESCRIPTION MEDICATIONS -- List all medications you are presently taking.

<u>Name and Dose</u>	<u>Prescribed by:</u>	<u>How Often</u>	<u>Date Started</u>
1 _____	_____	_____	_____
2 _____	_____	_____	_____
3 _____	_____	_____	_____
4 _____	_____	_____	_____
5 _____	_____	_____	_____
6 _____	_____	_____	_____
7 _____	_____	_____	_____
8 _____	_____	_____	_____
9 _____	_____	_____	_____
10 _____	_____	_____	_____
11 _____	_____	_____	_____
12 _____	_____	_____	_____

NON-PRESCRIPTION MEDICATIONS -- List all non-prescription medications you are presently taking. Include over-the-counter medications, vitamins/supplements, herbals, and creams.

<u>Name and Dose</u>	<u>How Often</u>	<u>Date Started</u>
1 _____	_____	_____
2 _____	_____	_____
3 _____	_____	_____
4 _____	_____	_____
5 _____	_____	_____
6 _____	_____	_____
7 _____	_____	_____
8 _____	_____	_____
9 _____	_____	_____
10 _____	_____	_____

CURRENT PHARMACY

<u>Name & Location</u>	<u>Phone Number</u>
Preferred: _____	_____
Other: _____	_____

ALLERGIES -- List all allergies or unusual reactions you have to medications, foods, dyes, latex, and other agents.

<u>Allergy</u>	<u>Reaction</u>
1 _____	_____
2 _____	_____
3 _____	_____
4 _____	_____

List any reactions to bug bites or stings.

ADULT IMMUNIZATIONS -- Check the box next to or list all immunizations received including the most recent date received.

	<u>Date Received</u>	<u>Others</u>	<u>Date Received</u>
<input type="checkbox"/> Tetanus	_____	_____	_____
<input type="checkbox"/> Flu	_____	_____	_____
<input type="checkbox"/> Pneumonia	_____	_____	_____
<input type="checkbox"/> HPV	_____	_____	_____
<input type="checkbox"/> Hepatitis B	_____	_____	_____

Today's Date _____

Patient Name _____

DOB _____

GHS UNIVERSITY MEDICAL GROUP

SURGICAL/SOCIAL/FAMILY HISTORY

HOSPITALIZATION & SURGICAL HISTORY -- List all hospital admissions and operations you have had.

<u>Reason for Hospitalization/Surgery</u>	<u>Year</u>
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.

	<u>Relationship</u>	<u>Age at onset</u>
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:		
Other:		

Today's Date _____

Patient Name _____

DOB _____

GHS UNIVERSITY MEDICAL GROUP

SURGICAL/SOCIAL/FAMILY HISTORY

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SCREENINGS -- List the most recent date and doctor for the following screenings.

	<u>Date</u>	<u>Doctor/Practice or Facility Name</u>
Complete medical physical	_____	_____
Full panel of lab work	_____	_____
Cholesterol (lipid) screening	_____	_____
Chest X-ray	_____	_____
Treadmill stress test	_____	_____
Other heart tests	_____	_____
Colonoscopy	_____	_____
Mammogram	_____	_____
Bone density	_____	_____



SC VFC Patient Eligibility Screening Record Form

Child's Name: _____ Date of Birth: _____
 (Patient label may be used) Last Name First Name MI

Provider: _____ FQHC RHC DHEC

A record must be kept by the healthcare provider that reflects the status of each child <19 years of age who receives immunizations by a VFC Provider.

Eligibility Screening Status (Referring to the key below, select one eligibility screening status per entry)					Date of Screening	Signature of Parent/Guardian/Individual of Record <i>By signing below, you are affirming that all information you have provided regarding Medicaid or other insurance is true and accurate.</i>
Medicaid	Uninsured	American Indian or Alaskan Native	Underinsured ¹ (Eligible for VFC vaccine at FQHC/RHC or DHEC only)	Insured ² (Not eligible for VFC vaccine)		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

¹ **Underinsured:** A child who has commercial (private) health insurance but the coverage does not include vaccines, a child whose insurance covers only selected vaccines (i.e., Insurance does not cover vaccine to be administered making the child VFC-eligible for non-covered vaccines only), or a child whose insurance caps vaccine coverage at a certain amount. Once that coverage amount is reached, the child is categorized as underinsured. **Underinsured children must only receive VFC vaccine in an FQHC, RHC, or DHEC clinic.**

² **Insured:** A child who has commercial (private) health insurance that includes coverage for vaccines. A child is considered fully insured even if a deductible has not yet been met and a claim for the cost of the vaccine and its administration would be denied for payment by the insurance carrier (high-deductible policy) or the parent must share in the cost of the vaccine(s) (e.g., co-pay or coinsurance).



Consents/Registration
Greenville Hospital System

CONSENT FOR TREATMENT

Name: _____

Date of Birth: _____

Gender: _____

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



Consents/Registration
Greenville Hospital System

CONSENT FOR TREATMENT

Name: _____

Date of Birth: _____

Gender: _____

FINANCIAL AGREEMENT: I understand that I am obligated to pay the patient's account according to the regular rates and terms of GHS. I do hereby appoint GHS as my true and lawful attorney 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 GHS to apply the overpayment to any other account for which I am responsible. If there are no other outstanding accounts for which I am responsible, the payment will be posted to the intended account and the refund processed accordingly. I understand GHS may obtain my/our 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, the undersigned shall pay all collection fees and reasonable attorney's fees.

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

CONTACTING PATIENTS: If for any reason GHS deems it necessary to contact me after discharge, I hereby authorize GHS to contact me by landline phone, cell phone, home address or through any other contact information provided at the time of pre-registration/registration.

DISCLOSURE/USE OF HEALTH INFORMATION: I hereby authorize GHS and attending physicians to provide any health information, including copies of the patient's medical records, related to this admission or course of treatment requested by an insurance company or other payor (such as Medicare) for purposes of payment for the health care provided. I further authorize GHS and attending physicians to disclose health information, including transferring copies of the medical records, available to other physicians and/or healthcare facilities as they deem necessary for the continuing care of the patient. I recognize and agree that GHS may use health information related to the patient for purposes of its own health care operations including but not limited to Medical Education, Peer Review and Outcomes Analysis Activities. I acknowledge by signing below that I have received a copy of GHS' Notice of Privacy Practices.

PHOTOGRAPHING AND VIDEOTAPING: GHS may photograph, film, videotape or otherwise make video and/or audio recordings of the patient for purposes of diagnosing and treating the patient's condition and any other reasonably related purposes.

PERSONAL VALUABLES/BELONGINGS: GHS is not responsible for personal property retained in the patient's room, including false teeth, glasses and other prosthetic devices. Furthermore, GHS will NOT be responsible for any of the patient's personal property, including money, unless receipt has been issued for the safekeeping of such personal property by GHS. We are a No Smoking Facility. To ensure your safety we must ask that you turn over to us your smoking materials until discharge. This policy is enforced by hospital security.

DATE SIGNATURE OF WITNESS SIGNATURE OF PATIENT/LEGALLY AUTHORIZED REPRESENTATIVE

DATE SIGNATURE OF SECOND WITNESS PRINT NAME AND RELATIONSHIP IF ABOVE SIGNATURE IS OTHER THAN PATIENT
(NECESSARY ONLY FOR TELEPHONE
CONSENT AND SIGNATURE WITH AN "X" OR A MARK)

THIS IS A TWO PAGE DOCUMENT

CHART COPY
M10029 (5/10)
CONSENT/REGISTRATION

Christie Pediatric Group

9 Mills Ave, Greenville, SC 29605
3911 S. Hwy 14, Greenville, SC 29615
1409 W. Georgia Rd, Suite A, Simpsonville, SC 29680

(Tel: 864-242-4840)
(Tel: 864-297-8890)
(Tel: 864-454-5062)



DISCLOSURE OF MEDICAL INFORMATION

Patient Full Name (PRINT) _____ DOB _____

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.

- Home: _____ Work: _____
- Cell phone: _____ 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) _____

Christie Pediatric Group

- 9 Mills Ave, Greenville, SC 29605 (Tel: 864-242-4840)
- 3911 S. Hwy 14, Greenville, SC 29615 (Tel: 864-297-8890)
- 1409 W. Georgia Rd, Suite A, Simpsonville, SC 29680 (Tel: 864-454-5062)

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION**ONE PER REQUEST**

Patient Full Name (PRINT) _____ SS# _____ DOB _____

is requesting that the Greenville Hospital System University Medical Group practice identified above release health information (check one) TO or obtain FROM the person/company/agency/facility listed below.

Name, Position, or Department:	
Name of Organization:	
Address of Organization:	
Phone number of Organization:	

The information to be disclosed relates to service dates beginning _____ and ending _____

<input type="checkbox"/> Entire medical record	<input type="checkbox"/> Medication List	<input type="checkbox"/> Physical Therapy notes
<input type="checkbox"/> Demographic Information	<input type="checkbox"/> Immunizations	<input type="checkbox"/> Occupational Health Record
<input type="checkbox"/> History & Physical	<input type="checkbox"/> Test Results (lab, X-ray, etc.)	<input type="checkbox"/> Other: (specify)
<input type="checkbox"/> Medical/Surgical History	<input type="checkbox"/> Other Assessments	<input type="checkbox"/> Other: (specify)
<input type="checkbox"/> Physician Office Visits	<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Other: (specify)

The purpose of the disclosure: ("Request of the Individual" is sufficient for patient-initiated releases)

<input type="checkbox"/> Request of Individual	<input type="checkbox"/> Change of Doctor	<input type="checkbox"/> Legal Investigation
<input type="checkbox"/> Referral to Specialist	<input type="checkbox"/> Insurance	<input type="checkbox"/> Other: (specify)
<input type="checkbox"/> Continuing Care	<input type="checkbox"/> Workers Comp	

CONDITIONS and NOTIFICATIONS:

This authorization for release of information expires 12 months from the date of patient's signature. You may revoke this authorization at any time by writing to the Office Supervisor at the address listed above. However, such notification will not affect any actions taken in reliance on this authorization prior to the time of receipt of the revocation. You may inspect or request a copy of the health information to be used or disclosed, consistent with federal law. This authorization is being given to the GHS UMG group practice identified above and to GHS and each practice and entity affiliated with it including GHS Partners in Health.

Note: There may be a processing fee charged to the patient to cover labor, copying, and supplies used to reproduce medical records.

SIGNATURES:

I hereby authorize the use or disclosure of the personal health information as described above. I understand that I may refuse to sign this authorization, that this authorization is voluntary and that my health care and the payment for my health care will not be affected if I do not sign this form. I also understand that if the individual or organization authorized to receive the information is not a health plan or health provider, the released information may no longer be protected by federal privacy regulations and, therefore, may be subject to re-disclosure.

Signature of Patient/Personal Representative: _____ Date: _____

PRINT Name of Personal Representative: _____

Relationship of Representative to Patient: _____

Released by: _____ Date: _____ <i>(Department Representative Name)</i>

Christie Pediatric Group

9 Mills Ave, Greenville, SC 29605

3911 S. Hwy 14, Greenville, SC 29615

1409 W. Georgia Rd, Suite A, Simpsonville, SC 29680

(Tel: 864-242-4840)

(Tel: 864-297-8890)

(Tel: 864-454-5062)



**Greenville Hospital System
University Medical Group***

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 in. 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: _____

CHRISTIE PEDIATRIC GROUP NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND RELEASED AND HOW YOU CAN GET THIS INFORMATION. PLEASE READ IT CAREFULLY.

Christie Pediatric Group makes every effort to keep your health information private. Each time you visit Christie Pediatric Group, a record is made. This health or medical record often includes your symptoms, exams and tests, diagnoses, treatment, and care plan. We need this record to give you high-quality care and to meet legal requirements. This Notice applies to all health records produced at Christie Pediatric Group, including those received from other providers. It outlines how we may use and give out information about you for treatment, payment, or healthcare operations, and other purposes granted or required by law. It also describes your rights to get and control your record, and legal requirements we have on its use and release. The law requires Christie Pediatric Group to do the following: (1) Keep your health record private (2) Describe our legal duties and privacy obligations related to your health information (3) Follow the current Notice of Privacy Practices

We reserve the right to change practices and terms of this Notice and the changes will be effective for the information we already have about you and any information we receive in the future. The Notice will list the start date in the top right-hand corner of the first page. Each time you register at Christie Pediatric Group, you may receive a copy of the notice. We will post it in our facilities and on our Web site (www.ghs.org). You may also call our Privacy Office at 864-455-3711 for a copy.

ROUTINE USES AND DISCLOSURES OF YOUR HEALTH RECORD The following sections describe how we use and release medical information. Each section explains what we mean and gives a few examples. (Note: These examples are not all-inclusive.)

Treatment. We use medical information about you to provide, coordinate, and manage your treatment or services. We may give this information to doctors, nurses, technicians, and students of affiliated healthcare programs, volunteers, or other staff who care for you. Various units may share information about you to coordinate your needs, such as lab work or drugs.

We may give details about you to people who are involved in your care, such as a specialist, spouse, or friend. Christie Pediatric Group medical personnel and employees, using their best judgment, may release to a relative, close friend, or other person information about your health related to that person's involvement in your care. Here is how your health record might be used for treatment reasons: We may send your record to specialists our doctors want to consult. (1) Your record may be sent to a doctor to whom you have been referred. (2) You may plan for a friend to pick you up after a procedure. A Christie Pediatric Group representative may believe it is in your best interest to tell your friend what drug you must take that night and what will speed your recovery at home. (3) We may use and release your health record to provide material on treatment options.

Payment. We use and release health information so that treatment and services you receive may be billed to and payment collected from you, an insurance company, or a third party. Here is how your health record might be used for payment purposes. (1) We may call your health plan for pre-approval of a service. (2) We may give your health plan details about your surgery, so it will pay us or reimburse you. (3) If someone else is responsible for your payment, we will contact that person.

Healthcare Operations. We may use and release your record to support our business functions (for example, administrative, financial, and legal activities). These uses and disclosures are needed to run the practice; support treatment and payment, and help patients receive high-quality care. Activities may include measuring quality, reviewing employee performance, and training students. Here is how your health record might be used for business operations. (1) We may call you to confirm your appointment. (2)

We may ask you to list your name and your doctor's name when you arrive for a visit. We may also call you by name in a waiting area. (3) We may use health information to review our treatment and services. (4) We may combine information on Christie Pediatric Group patients to decide what services to offer. (5) We may give information to doctors, nurses, technicians, students, and other staff for review and learning purposes. (5) We may combine our records with those from other hospitals or practices to compare how we are doing and where we can improve.

Facility Directory. Unless you object in writing, we include certain facts about you in our directory while you are a patient at Christie Pediatric Group. These facts may include your name, location, and general condition (for example, fair, serious, undetermined).

People Involved in Your Care or Payment for Your Care. Unless you object, Christie Pediatric Group health experts may tell a family member, friend, or other person you identify, or that we have a reasonable basis to believe is involved in your medical care, details about you that relate to that person's involvement in your care. If you cannot physically or mentally agree or object to a disclosure, we may supply information as needed. We may also give information to someone who pays for your care. Finally, we may share facts with someone helping in a disaster relief effort so that family can know of your condition, status, and location.

Business Associates. Business associates of Christie Pediatric Group provide some services related to treatment, payment, and business operations. Examples include medical supplies, transcription, medical record storage, and some aspects of billing. We have a written contract that requires associates to protect your record in the course of performing their job.

SPECIAL USES AND DISCLOSURES OF YOUR HEALTH RECORD

Emergencies. We may use or release your health information during emergencies.

Communication Barriers. We may use or release your record if we try to get your consent but cannot because of major communication barriers and the doctor or staff decides that you intend to consent to use or release such information.

Research. Christie Pediatric Group may release your record for research approved by the Greenville Hospital System's Institutional Review Committee (IRC). The IRC reviews proposals and protocols to ensure privacy. We may share information about you with researchers starting a project to help them find patients with specific needs (the information will not leave Greenville Hospital System).

Fundraising Events. We may use your name, address, and dates that you received treatment for Greenville Hospital System-supported fundraising events. Any fundraising material sent to you will include information telling you what to do to keep from receiving any future communications.

Workers' Compensation. We may release information about you to comply with workers' compensation laws or similar programs.

Legal Proceedings. We may release health information about you for the following reasons: Court or administrative order, and/or subpoena, discovery request, or other lawful process.

Legal Requirements. We will give out medical information about you when required to do so by federal, state, or local law.

Continued on Reverse

Serious Threat to Health or Safety. We may use and release information about you to prevent a serious threat to your health and safety or the health and safety of others.

Health Oversight Activities. We may supply information to a health oversight agency for activities authorized by law, such as audits, investigations, inspections, and licensure. These activities help the government oversee healthcare systems, benefit programs, and civil rights laws.

Public Health Risks. We may release information about you to local, state, or federal public health agencies (such as the Food and Drug Administration and the Department of Health and Environmental Control) for reasons such as: (1) To prevent or control disease, injury, or disability (2) To report births and deaths (3) To report adverse events, product defects or problems, or drug reactions (4) To note product recalls (5) To notify a person who may have been exposed to a disease or may be at risk for getting or spreading one (6) To alert a government agent if we believe a patient is the victim of abuse, neglect, or domestic violence.

Coroners, Funeral Directors, and Organ Donors. We may release information to coroners or medical examiners to identify a deceased person, find cause of death, or carry out duties as required by law. We may also give information to funeral directors to meet their duties and may share such information in the reasonable anticipation of death. We may supply your health record to organ donor groups as approved by you or consistent with the law.

Military, Veterans, and National Security. If you are a member of the armed forces, we may release information about you as required by military authorities. We may also share information about foreign military personnel to the appropriate foreign military authority. We may give information about you to federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Law Enforcement. We may release your health information to a law enforcement official: (1) In response to a court order, subpoena, warrant, summons, or similar legal process (2) To identify or locate a suspect, fugitive, witness, or missing person (3) To provide information about the victim of a crime if, under certain cases, we cannot get the person's agreement or as required by law (4) In case of a death we believe may be the result of criminal conduct (5) In response to criminal conduct at this facility (6) In an emergency to report a crime; the location of the crime or victims; or the identity, description, or location of the person who committed the crime.

Inmates. If you are an inmate of a correctional institution or in custody of a law enforcement official, we may release medical information about you to that facility or person.

YOUR HEALTH INFORMATION RIGHTS

Review and Copy. You have the right to review and request a copy of your health record (this often includes medical and billing records but, under federal law, excludes psychotherapy notes). To do so, write to Christie Pediatric Group, 9 Mills Ave, Greenville, SC 29605. There may be a fee for copying, mailing, and related supplies. We may deny your request to inspect and copy in certain cases. Then you may request a review. Another licensed healthcare professional chosen by Christie Pediatric Group will examine your request. The reviewer will not be the person who denied your request. Christie Pediatric Group will comply with the outcome of the review.

Amend. If you believe that information we have about you is incorrect or incomplete, you may ask us to modify or add the information. You have the right to request a change or addition for as long as Christie Pediatric Group keeps the record. Request your change in writing to Christie Pediatric Group, 9 Mills Ave, Greenville, SC 29605. You must give a reason that supports your request. We may deny your request if it is not in writing or does not include a reason to support the request. We may also deny a request

to modify a medical record in these cases: (1) The current information is accurate and complete (2) It is not part of the medical information kept by or for Christie Pediatric Group (3) It is not part of what you would be allowed to view and copy (4) It was not created by us. If we deny this request, you have the right to file a statement of disagreement. We may then prepare a rebuttal. We will give you a copy of the rebuttal.

Accounting of Disclosures. You have the right to request an "accounting of disclosures" (a list of disclosures made about you for reasons other than treatment, payment, Christie Pediatric Group operations, or national security). Request this list by writing to Christie Pediatric Group, 9 Mills Ave, Greenville, SC 29605. Your request must state a period of time, which may not be longer than six years and may not include dates before April 14, 2003. The first list you request within a 12-month period will be free. Additional lists may involve a charge. We will notify you of the cost, and you may cancel or adjust your request before any fees are incurred.

Request Restrictions. You have the right to request that we limit information we use or give out about you for treatment, payment, or healthcare operations. You also have the right to request a limit on what we release to someone involved in your care or payment for your care, such as a family member. For example, you could ask that we not use or give out information about a surgery that you had to your family. ***We are not required to agree to your request.*** If we do agree, we will comply with your request unless the material is needed for emergency treatment. To request restrictions, submit a Restriction of Information Agreement Form to Christie Pediatric Group' registration personnel. State (1) what you want to limit; (2) if you want to limit use, release, or both; and (3) to whom the limits should apply, for example, disclosures to your family.

Request Confidential Communications. You have the right to request that we interact with you about medical matters in a certain way or place. For example, you can ask that we contact you only by mail or only at work. To request confidential communications, submit a Restriction of Information Agreement Form to Christie Pediatric Group' registration personnel. We will try to meet all reasonable requests. You must note how or where you wish to be contacted.

Paper Copy of This Notice. You have the right to a paper copy of this Notice at any time. For a paper copy, call Christie Pediatric Group at 864-454-2670 or the Greenville Hospital System Privacy Office at 864-455-3711. You may also get a copy from our web site, www.ghs.org

COMPLAINTS If you believe your privacy has been violated, you may file a complaint with Christie Pediatric Group, Greenville Hospital System or with the Secretary of the Department of Health and Human Services. To file a complaint, call the Practice Manager of Christie Pediatric Group at 864-242-4840, or call our Privacy Office at 864-455-3711 or the GHS Service Excellence Department at 864-455-7975. You may also file an anonymous complaint through our Corporate Compliance Hotline at 1-888-243-3611 (1-800-297-8592 en Espanol). To ensure proper follow-up, complaints must also be submitted in writing.

OTHER USES. Other uses and disclosures of medical information not covered by this notice or relevant laws will be made only with your written consent. If you allow us to use or release health information about you, you may cancel that consent, in writing, at any time. If you revoke it, we will no longer use or release information for the reasons covered by your written consent. **Note:** We cannot take back disclosures already made with your consent.

May 2011