SINGLETON HEALTH CENTER

1773 VILLAGE PARK DRIVE
ORANGEBURG, SC 29118

MEDICAL CENTER of SANTEE

500 BASS DRIVE
SANTEE, SC 29142

PATIENT REGISTRATION

PLEASE PRINT AND COMPLETE ALL ENTRIES

PATIENT NAME (LAST -- FIRST -- MIDDLE INITIAL)	ADDRESS		
CITY, STATE	ZIP	HOME PHONE	CELL PHONE
PATIENT DATE OF BIRTH	PATIENT SSN	SEX ☐ Male ☐ Female	MARITAL STATUS ☐ Single ☐ Married ☐ Other__________
PATIENT EMPLOYER NAME	PATIENT EMPLOYER ADDRESS (STREET ADDRESS - CITY - STATE - ZIP)	EMPLOYER PHONE	

INSURED/RESPONSIBLE PARTY INFORMATION RELATION TO PATIENT: ☐spouse ☐parent ☐guardian

NAME (FIRST -- LAST -- MIDDLE INITIAL)	ADDRESS (if different from patient)			
HOME PHONE	WORK PHONE	SSN	BIRTH DATE	EMPLOYER

INSURANCE INFORMATION

PRIMARY INSURANCE NAME	ADDRESS (STREET - CITY - STATE - ZIP)	PHONE	
GROUP NUMBER	ID NUMBER	EMPLOYER	EMPLOYER PHONE
SECONDARY INSURANCE NAME	ADDRESS (STREET - CITY - STATE - ZIP)	PHONE	
GROUP NUMBER	ID NUMBER	EMPLOYER	EMPLOYER PHONE

PRIMARY DOCTOR/FAMILY DOCTOR	REFFERING DOCTOR	
IN CASE OF EMERGENCY CONTACT	RELATIONSHIP	PHONE NUMBER

FINANCIAL AGREEMENT:
I acknowledge, that as a courtesy, the practice may bill my insurance company for services provided to me. I agree to pay for services that are not covered or covered charges not paid in full including, but not limited to any co- payment, co- insurance and/or deductible, or charges not covered by insurance. I understand there is a fee for returned checks ($30.00)

GENERAL RELEASE/ASSIGNMENT OF BENEFITS: I hereby authorize my insurance benefits be paid directly to the physician and I am financially responsible for non-covered services. I also authorize the physician to release any information required in the processing of this claim and all future claims. If my account is sent to a collection agency, I agree to pay all collection and attorney fees.

MEDICARE RELEASE/ASSIGNMENT OF BENEFITS: I certify that the information given by me in applying for payment under Title XVIII of the social Security Act is correct. I authorize the holder of medical or other information about me to be released to the Social Security Administration or its intermediaries or carriers, or any additional third party responsible for payment of benefits, any information needed for this or any Medicare claims.

SIGNATURE (Patient or, if minor Signature of parent or guardian)	**DATE**

☐**Verified Patient Information** Staff Initials: __________

Authorization to release health information to:

Name(s)		ADDRESS	
CITY, STATE	ZIP	HOME PHONE	DAYTIME PHONE
DATES OF SERVICE FROM: TO:	AUTHORIZATION EXPIRES (UNLESS OTHERWISE NOTED THIS AUTHORIZATION WILL REMAIN IN EFFECT ONE YEAR FROM THE DATE SIGNED) DATE:		

Release the following information:

❑ All Records ❑ Chart Notes ❑ Radiology Reports ❑ Operative Reports ❑ History & Physicals

RELEASE OF INFORMATION

I understand that:

- once "this facility" discloses my health information by my request, it cannot guarantee that Recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state laws governing the use and disclosure of my health information.
- I may make a request in writing at any time to inspect and/or obtain a copy of my health information maintained at this facility as provided in the Federal Privacy Rule 45 CFR (164.524).
- my records are protected and cannot be disclosed without written permission
- this Authorization will remain in effect for one year or I provide a written notice of revocation to the Medical Record Department.

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE	DATE	EMAIL
IF SIGNED BY LEGAL REPRESENTATIVE, RELATIONSHIP TO PATIENT	SIGNATURE OF WITNESS (Optional):	

Disclosure to Family or Loved Ones: Emergency Contacts

I authorize Singleton Health Center to disclose my health care information and to discuss my health care needs to those that I designate. I further authorize the release of my billing information and give these individuals the ability to pick up prescriptions and/or medications on my behalf. A photo ID is required for prescription pickup. These individuals will be considered my emergency contacts. Without authorization, no information may be shared. I authorize Singleton Health Center to disclose my personal health information to the following people:

Name: ______________________ Relationship: __________ Phone: (____)__________

Name: ______________________ Relationship: __________ Phone: (____)__________

Name: ______________________ Relationship: __________ Phone: (____)__________

CONSENT TO TREATMENT FOR ALL PATIENTS

I hereby grant authorization and consent for medical treatment and/or procedures for myself or the patient for whom I am the parent or legally authorized representative for which I am signing for, and understand that no guarantee or assurance has been made as to the results for which may be obtained. I agree to allow my provider to access all of my medication history including medications prescribed by other providers.

____
Patient initials

AUTHORIZATION FOR E-PRESCRIBE

I hereby grant authorization to electronically submit prescriptions on my behalf. I also grant permission to access my prescription history from outside sources.

____
Patient initials

NOTICE OF PRIVACY PRACTICES

I received a copy of the Singleton Health Center's "Notice of Privacy Practices" today and agree with these privacy policies.

____
Patient initials

PATIENT MEDICAL HISTORY

PATIENT NAME (LAST -- FIRST -- MIDDLE INITIAL)

***** Preferred Pharmacy:**

Allergies

- ❑ NONE/No Known Allergies
- ❑ Adhesive Tape
- ❑ Anesthesia
- ❑ Aspirin
- ❑ Codeine
- ❑ Dairy Products
- ❑ Iodine/Shellfish/Contrast Dye
- ❑ Latex
- ❑ Morphine
- ❑ Penicillin
- ❑ Sulfa Drugs
- ❑ Wheat

OTHER:

FAMILY HISTORY – Please indicate if any of your immediate relatives have had any of the following by placing an X in the appropriate box.

	MOTHER	FATHER	SIBLING (Brother/Sister)
Arthritis			
Cancer			
Diabetes			
Heart Problems			
Hypertension			
Stroke			
Thyroid Disorder			

SOCIAL HISTORY

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Occupation: ______________________________ ☐ Retired ☐ Disabled (reason ______________________________)

☐**Yes** ☐**No -** Do you drink alcohol? ☐ Daily ☐Weekly ☐Infrequently ☐ Recovering Alcoholic

☐**Yes** ☐**No -** Do you use tobacco? ☐ Smoke (___ packs per day) ☐ Chew

Surgical History: Please list any hospitalizations, surgeries, fractures or major illnesses you have had.

TYPE OF SURGERY

Medical History: Have you ever had any of the following?

- ❑ NONE of the problems listed
- ❑ allergies
- ❑ anemia
- ❑ arthritis conditions
- ❑ asthma
- ❑ arterial fibrillation
- ❑ bleeding problems
- ❑ BPH
- ❑ CAD coronary artery disease
- ❑ cancer
- ❑ cardiac arrest
- ❑ celiac disease
- ❑ CHF congestive heart failure
- ❑ chronic fatigue syndrome
- ❑ depression
- ❑ diabetes
- ❑ drug/alcohol abuse
- ❑ erectile dysfunction
- ❑ fibromyalgia
- ❑ Gerd
- ❑ heart disease
- ❑ high cholesterol
- ❑ hyperinsulinemia
- ❑ hypertension
- ❑ hypogonadism male
- ❑ hypothyroidism
- ❑ infection problems
- ❑ insomnia
- ❑ irritable bowel syndrome
- ❑ kidney problems
- ❑ menopause
- ❑ migraines/headaches
- ❑ neuropathy
- ❑ onychomycosis
- ❑ osteoporosis
- ❑ pulmonary embolism/blood clot in legs
- ❑ seizure disorders
- ❑ shortness of breath
- ❑ sinus conditions
- ❑ stroke
- ❑ syndrome X
- ❑ tremors
- ❑ wheat allergy

Medications: List any medications you are currently taking (please include over the counter medications):
PLEASE PRINT LEGIBLY – NO CURSIVE PLEASE

MEDICATION

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.

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, legal obligations, and your rights concerning your health information ("Protected Health Information" or "PHI"). We must follow the privacy practices that are described in this Notice (which may be amended from time to time). For more information about our privacy practices, or for additional copies o this Notice, please contact us using the information listed at the end of this Notice.

I. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION:

a. **Your PHI may be used and disclosed by the physician, our office staff and others outside our offices that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the business, and any other use required by law. We may use and disclose PHI without your written authorization for certain purposes as described below. The examples provided in each category are not meant to be exhaustive, but instead are meant to describe the types of uses and disclosures that are permissible under federal and state law.**

i. **Treatment:** We may use and disclose PHI in order to provide treatment to you. For example, we may use PHI including your medication history, to diagnose, treat, and provide medical services to you. In addition, we may disclose PHI to other health care providers involved in your treatment.

ii. **Payment:** Under federal law we may use or disclose PHI so that services you receive are appropriately billed to, and payment is collected from your health plan. By way of example, we may disclose PHI to permit your health plan to take certain actions before it approves or pays for treatment services. Under South Carolina state law, release of PHI to health plans require an authorization provided by you to us or to your health plan. We may contact the Guarantor for your visit in order to obtain payment.

iii. **Health Care Operations:** We may use or disclose your PHI in order to support our business activities. These activities include, but are not limited to business associates, quality assessment activities, internal investigations, performance reviews, and training employees. In addition, we will use a sign in sheet at the registration desk where you will be asked to provide your name and date o birth. We may also call you by name in the waiting room when the physician is ready to see you. We may use or disclose your PHI to contact you to remind you of an appointment, to notify you of test results, to inform you of health-related services that may be of interest to you, and to check on your treatment, progress, and satisfaction with our services.

iv. **Required of Permitted by Law:** As required by law, Public Health issues as required by law, Communicable diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement Concerns, Funeral Directors, Organ Donation, Research, Criminal Activity, Military Activity, National Security, Worker's Compensation, Inmates and other required uses and disclosures. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services.

b. **Permissible Uses and Disclosures That May Be Made Without Your Authorization, But For Which You Have An Opportunity to Object**

i. **Family and Other Persons Involved in Your Care.** We may use or disclose health information to notify or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience to make reasonable inference of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

ii. **Disaster Relief Efforts.** We may use or disclose protected health information to a public or private entity authorized by law or it's charter to assist in disaster relief efforts for the purpose of coordinating notification of family members of your location, general condition, or death.

c. **Other Permitted and Required Uses and Disclosures:** Use or Disclose of your PHI for marketing or sale of your PHI to third parties will be made only with your authorization. Once given, you may withdraw authorization at any time in writing.

II. YOUR INDIVIDUAL RIGHTS

a. **Right to Inspect and Copy.** You may request access to your medical records and billing records maintained by us in order to inspect and request copies of the records. All requests to access must be made in writing. Under limited circumstances, we may deny access to your records. Under federal law, you may not inspect or copy psychotherapy notes, information complied in anticipation of, or use in a legal proceeding, and PHI that is otherwise prohibited. We may charge a fee for the costs of copying and sending you any records requested.

b. **Right to Alternative Communications.** You may request, and we will accommodate, and reasonable written request for you to receive PHI by alternative means of communication or at alternative locations.

c. **Right to Request Restrictions.** You may ask us not to disclose any part of your PHI for the purposes of treatment, payment, or health care operations. Your request must be in writing and state the specific restriction requested and to who you want the restriction to apply. If you have paid for your services in full and ask us not to disclose your visit to your insurance company, we will honor that request. We are not required to agree to any other restriction that you may request.

d. **Right to Accounting of Disclosures.** Upon written request, you may obtain an accounting of certain disclosures of PHI made by us in the last six years. This right applies to disclosures for purposes other than treatment, payment, or health care operations, excludes disclosures made to you or disclosures otherwise authorized by you, and is subject t other restrictions and limitations. We are required by law to notify you if your unsecured PHI is breached.

e. **Right to Request Amendment.** You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances. If we deny your written request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and provide you with a copy of any such rebuttal.

f. **Right to Obtain Notice.** You have the right to obtain a paper copy of this Notice by submitting a request to the center's Compliance Officer at any time.

g. **Questions and Complaints.** If you desire further information about your privacy rights, or are concerned that we have violated your privacy rights, you may contact the center's Compliance Officer. You may also file a written complaint with the Director, Office for Civil Rights of the U.S. Department of Health and Human Services. We will not retaliate against you if you file a complaint with the Director or with our office.

III. EFFECTIVE DATE AND CHANGES TO THIS NOTICE

a. **Effective Date.** The Notice is effective on January 01, 2020.

b. **Changes to this Notice.** We may change the terms of this Notice at any time. If we change this Notice, we may make the new notice terms effective for all PHI that we maintain, including any information created or received prior to issuing the new notice. If we change this Notice, we will post the revised notice in the waiting area of our office and on our website. You may also obtain any revised notice by contacting the center's Compliance Officer.