MEDICAL GROUP OF THE CAROLINAS

GENERAL CONSENT TO TREAT/
PATIENT AUTHORIZATION/ACKNOWLEDGEMENT OF BENEFITS RELEASE

The following are the conditions for services provided by the Medical Group of the Carolinas which is affiliated with Spartanburg Regional Health Services District, Inc. (District) for the patient whose name appears at the bottom of this page.

CONSENT FOR MEDICAL TREATMENT

I/we voluntarily consent to medical treatment and diagnostic procedures provided by Medical Group of the Carolinas and its associated physicians, clinicians and other personnel. I/we consent to the testing for infectious diseases, such as, but not limited to syphilis, AIDS, hepatitis and testing for drugs if deemed advisable by my physician. I/we am/are aware that the practice of medicine and surgery is not an exact science and I/we acknowledge that no guarantees have been made as to the result of treatments or examinations.

AUTHORIZATION FOR RELEASE OF INFORMATION

The practice and physicians are authorized to release any medical information required in the processing of applications or submission of information for financial coverage, discharge planning and further medical treatment. To include information referring to psychiatric care, sexual assault or tests for infectious diseases including AIDS/HIV for services provided during this visit. I/we also agree to the release of medical or other information about me to government federal or state regulatory agencies as required by law.

TELEPHONE AUTHORIZATIONS

You hereby grant permission and consent to us, our assignees, and third party collection agents: (1) to contact you by telephone at any telephone number associated with you, including wireless numbers: (2) to leave answering machine and voicemail messages for you, and include any such messages information required by law (including debt collection laws) and/or regarding amounts owed by you: (3) to send you test messages or emails using any email addresses you provide: (4) to use pre-recorded/artificial voice messages and/or an automatic dialing device (an "auto dialer") in connection with any communications made to you or related to your account.

ASSIGNMENT OF INSURANCE BENEFITS

I/we guarantee payment of all charges made for or on account of the patient and I/we assign our rights in any insurance benefits or other funding to the physician and the Medical Group of the Carolinas. I/we understand that I/we am/are responsible for any charges not covered by insurance or other forms of benefits. I/we understand the Medical Group of the Carolinas can 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 attorney for collection or collected following the SC Setoff Debt Collection Act, I/we shall pay all collections fees and costs, including reasonable attorney's fees. For Medicare beneficiaries: I/we have provided all necessary information for proper assignment of Medicare benefits.

WORKER'S COMPENSATION PATIENT RECORDS RELEASE AND AUTHORIZATION FORM

I understand that South Carolina and North Carolina Worker's Compensation law provides that written information which pertains directly to a workers' compensation claim must be provided by a healthcare facility/physician to the insurance carrier, the employer, the employee, their attorneys, or the applicable State Workers' Compensation Commission pursuant to the SC Code Ann § 42-15-95 and NC ST § 97-27. **I authorize Spartanburg Regional Healthcare System (SRHS) to provide copies of my medical records or to speak to duly authorized representatives of any of the above regarding my medical records, medical treatment, or condition.**

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I/we have received a copy of the Notice of Privacy Practices. The notice describes how my health information may be used or disclosed. I understand that I should read it carefully. I am aware that the Notice may be changed at any time. The Notice of Privacy Practices may be accessed at www.srhs.com.

_____
Date

_____
Signature of Patient/(Relationship to Patient)
(Parent, Guardian or Legally Authorized Representative)

_____
Hospital Witness

_____
Signature of Guarantor (Relationship to Patient)

Spartanburg Regional Healthcare System

Medical History/Review of Symptoms

Patient Name: _____

Yes	No	List allergies you have:
		Allergies (specify):

Yes	No	List medications you take:
		Medications (specify):
		1.
		2.

Yes	No	Do you have any of the following?
		Cancer (specify type):
		Asthma
		Heart Disease (CAD)
		Stroke (CVA)
		Depression / anxiety
		Diabetes
		Diverticulitis
		Hyperlipidemia
		Hypertension
		Hypothyroidism
		Peptic ulcer
		Other:

Yes	No	Have you had Surgeries or Operations?
		Surgeries (specify):

Yes	No	Does your family have any of the following?		
		Blood Diseases:	❑ Father	❑ Mother
		Cancer or Leukemia:	❑ Father	❑ Mother
		Diabetes:	❑ Father	❑ Mother
		Heart Disease:	❑ Father	❑ Mother
		High Blood Pressure:	❑ Father	❑ Mother
		Strokes:	❑ Father	❑ Mother
		Mental Illnesses:	❑ Father	❑ Mother

Yes	No	Do you use alcohol, drugs or smoke?
		Tobacco Use: How much ? _____ Week.
		Alcohol Use: How much ? _____ Week.
		Drug Use: Describe use & drug: _____.

Yes	No	Are you employed?
		How long Employed?
		Position?

Yes	No	Menstrual History (woman):
		Are you pregnant?
		Last menstrual date?
		Last pap smear date?
		Left or right handed? ❑ Left ❑ Right
		Last Tetanus shot date?

Are you experiencing any of the following conditions/symptoms TODAY?

Yes	No	CONSTITUTIONAL
		Change in appetite
		Chills
		Fatigue
		Fever
		Sweats
		Weight loss
Yes	**No**	**EYES AND VISION**
		Blurred or double vision
		Contact lenses
		Eye discharge
		Eye pain
Yes	**No**	**EARS, NOSE , THROAT, TEETH**
		Dizziness
		Ear pain
		Nasal congestion
		Nose discharge
		Sneezing
		Sore throat
Yes	**No**	**CARDIOVASCULAR / HEART**
		Chest pain or pressure
		Fainting
		Irregular heart beat
Yes	**No**	**RESPIRATORY / LUNGS**
		Congestion
		Cough
		Shortness of breath
		Wheezing
Yes	**No**	**GASTROINTESTINAL SYSTEM**
		Abdominal pain
		Diarrhea
		Nausea
		Urinary / Bowel changes
		Vomiting

Yes	No	GENITOURINARY
		Discharge
		Frequent urination
		Nighttime urination
		Painful urination
Yes	**No**	**MUSCULOSKELETAL**
		Joint pain
		Muscle pain
		Swelling
Yes	**No**	**SKIN**
		Easy bruising
		Rash / Itching
		Redness
		Skin sores
Yes	**No**	**NEUROLOGICAL**
		Headache
		Light headedness
		Numbness
		Poor balance
		Tingling
		Weakness
Yes	**No**	**PSYCHIATRIC**
		Anxiety/Nerves
		Depression
Yes	**No**	**ENDOCRINE SYSTEM**
		Diabetes
		Hyper or hypothyroid
		Heat or cold intolerance
Yes	**No**	**HEMATOLOGIC/BLOOD DISORDERS**
		Frequent infections
		Swollen glands
Yes	**No**	**IMMUNE SYSTEM**
		Hay fever or allergies
		Food allergies

Patient Vitals: Height ____ Weight ____ Temp ____ BP ____ / ____ Pulse ____ Resp ____ PO % ____ Room ____

Chief Complaint _____

Signature: _____

Date: _____

Corporate Health
New Patient Welcome Sheet

Spartanburg Regional Healthcare System

Sptbg County Employee Health Clinic Medical History forms

Date: _____

Why are you here today?

What are here for today? (Chief Complaint): _____

_____

Date of Illness / Injury: _____ Time of Illness / Injury: _____

Patient Information:

Last Name: _____ First Name: _____ Social Security: _____ - _____ - _____

Street Address: _____ Birth Date: _____ Age: _____

City, State, Zip: _____ Home Phone: _____

Other Address: _____ Work Phone: _____

Sex: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married DL #: _____

Person to contact in case of Emergency: _____ Phone: _____

Patient Employer or Guarantor:

Employer Name: _____ Department: _____

Street Address: _____ Employer Phone: _____

City, State, Zip: _____ Supervisors Name: _____

Other Address: _____ (_____

Occupation: _____ _____

Insurance Information:

Is the insurance carrier responsible for your visit, your private insurance or your employer's workers compensation insurance?

☐ Private Insurance ☐ Employer's Workers Comp Insurance Name of Insurance _____

Assignment of Benefits - Financial Agreement:

I hereby authorize _____ to examine and treat my condition as the doctors deem appropriate and I give authority for these procedures to be performed. I clearly understand and agree that all services rendered are charged directly to me and that I am responsible for payment of services by this office and all outside laboratory or radiology services performed on my behalf. Should collection of past due amount become necessary, I will become responsible for all charges, fee and attorney fees. I (we) hereby authorize the doctor/provider to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Patient / Guardian: _____ Date: _____

Consent to Treat a Minor: YOU MUST HAVE DOCUMENTATION OF GUARDIANSHIP AND/OR CUSTODY PAPERWORK WHEN BRINGING IN A MINOR

I (we) being the parents, guardian or custodian of the minor being:

Last _____ MI _____ First _____. Age _____, do hereby authorize, request, and direct Work Fit, the doctors and staff to per- form examinations, diagnostic, X-ray, laboratory tests, and any treatment that in their judgment is deemed advisable or is required while said minor child is under care of this office's doctors and staff until legal age. All charges for service and care given to said minor child will be charged directly to me (us) and I (we) will be personally responsible for payment of them. I (we) hereby authorize the doctor/provider to release all information necessary to secure payments of benefits. I authorized the use of this signature on all insurance submissions.

Parent, Guardian, or Custodian Signature: _____ Date _____

Relationship to Patient: _____ Witness _____ Date _____