BON SECOURS
MEDICAL GROUP

Patient Information

Last Name:	First Name:	Middle:
Sex: ☐ Female ☐ Male	DOB:	SSN:
Address:		
City:	State:	Zip:
Home #: Primary ☐	Work #: Primary ☐	Cell #: Primary ☐
Email:	Language:	Marital Status:
Emergency Contact Name:		
Relationship to Patient:	Phone:	
Primary Care Physician:	Phone:	
Employment Status: ☐ Full Time ☐ Part Time ☐ Retired	Employer Name:	
Referring Physician:		

Responsible Party

Last Name:	First Name:	
Sex: ☐ Female ☐ Male	DOB:	SSN:
Address:		
City:	State:	Zip:
Home #: Primary ☐	Work #: Primary ☐	Cell #: Primary ☐
Employment Status: ☐Full Time ☐ Part Time ☐ Retired	Employer Name:	

Primary Insurance Information

Insurance Name:	Subscriber ID:	
Group Number:	Group Name:	
Relationship to Insured:	Subscriber Name:	
Sex: ☐ Female ☐ Male	DOB:	SSN:
Address:		
City:	State:	Zip:

Secondary Insurance Information

Insurance Name:	Subscriber ID:	
Group Number:	Group Name:	
Relationship to Insured:	Subscriber Name:	
Sex: ☐ Female ☐ Male	DOB:	SSN:
Address:		
City:	State:	Zip:

Accident Related

Is this related to: Worker's Comp _____ Auto _____ Other (please specify) _____	Date of Injury: _____ Accident State (if auto): _____ Claim Number: _____ Bill to: _____

PLEASE COMPLETE EACH SECTION
PATIENT HISTORY FORM

Today's Date: _____

Name: _____ Date of Birth: _____

FAMILY HISTORY: _____ Heart Disease, _____ Stroke, _____Hypertension, _____Diabetes Mellitus, _____Cancer, _____Other
Who? (Example: Mother, Father, Sister, & Brother):_____

PATIENT HISTORY (Please place a check below for any past or ongoing medical problems). _____ NONE OF BELOW

_____Allergies/ Sinus Problems
_____AIDS/HIV
_____Anemia
_____Anxiety
_____Arthritis
_____Asthma/COPD
_____Back Problems
_____Broken Bones
_____ Cancer
_____Circulation Problems
_____Colon Polyps
_____Crohns/Ulcerative Colitis
_____Depression
_____Diabetes
_____Diverticulitis
_____Emphysema/COPD
_____Epilepsy/Seizures
_____Fibromyalgia
_____Ear Problems
_____GERD (Reflux)
_____Hiatal Hernia
_____Headaches
_____Hearing
_____Heart Problems
_____Hepatitis
_____Hernia
_____High Blood Pressure
_____Irritable bowel/Spastic Colon
_____Kidney Problem
_____Muscular Disease
_____Pancreatitis
_____Phlebitis/Blood clot
_____Psychiatric Problem
_____ Paralysis
_____ Pneumonia
_____ Prostate Problem
_____ Skin Rash or Eczema
_____ Stomach Ulcer
_____ Stroke/TIA
_____ Thyroid Problems
_____ Tuberculosis
_____ Urinary Tract Infection
_____ Venereal disease (STD)
_____ Visual or Eye Problem
_____ Other _____

DATE OF LAST:

Colonoscopy when: _____ Flu Shot When: _____ Prostate Exam When: _____
Chest X-ray when: _____ EKG When: _____ Pneumonia Shot When: _____
Tetanus Shot when: _____ Pap Smear When: _____ Mammogram When: _____

REVIEW OF SYSTEMS:

Please place check below by any symptom or condition you are experiencing *now* or in the past few days:

_____Fatigue, Excessive
_____Fever
_____Eye or Ear pain
_____Chest pains, pressure or tightness
_____Palpitations (heart fluttering)
_____Shortness of breath
_____Frequent coughing
_____Wheezing
_____Abdominal pain
_____Blood in stool or black stool
_____Nausea or vomiting
_____Diarrhea / Constipation
_____Neck pain or stiffness
_____Burning w/urination or frequency
_____Blood in urine
_____Difficulty swallowing
_____Leg cramps when walking
_____Swelling of hands or feet
_____Joint pains
_____Back Pain
_____Headache
_____Dizziness
_____Fainting or passing out
_____Weakness in arm or leg
_____Depression or anxiety
_____Pregnancy
_____Heartburn
_____ Other _____

Ever used tobacco (smoke, chew, dip)?
Yes_____ No _____
How much? _____
Date quit? _____

Ever used alcohol (wine, beer, liquor)?
Yes_____ No_____
How often?_____

Current or past abuse of drugs?
Yes_____ No_____
Type of Drug?_____

Type of Occupation (job)?_____
_____

Operations or surgeries: _____
Recent Hospitalizations (past 3 years): _____

(All information is treated as confidential unless you grant permission to release it)

Created 05/15/2012/la

COVENANT
PRIMARY CARE

Office Policies and Patient Acknowledgement

Office Hours

- Monday, Tuesday, Thursday, Friday 8am to 4:30pm and Wednesday 8am-12pm
- We are closed daily for lunch from 12:00pm to 1:00pm

Appointments

- Appointments may be scheduled during normal office hours by calling our main number 864-365-0200. If you are a new patient, you should arrive 30 minutes prior to your scheduled appointment so we may complete the registration process. Please bring your insurance card(s) with you as we will need this to file your insurance and verify benefits. We also need you to bring your driver's license or some form of photo identification.
- It is very important for you to bring all your medications and your medication formulary (which is provided by your insurance company) with you for each visit to our office.
- Please be advised you may be subject to a $50 penalty for missed office visits and $100 penalty for missed complete physical visits, if these appointments are not cancelled within 24 hours of your scheduled appointment time.

Emergencies

- For after-hours care which does not require immediate medical attention, please call our office at 864-365-0200. Our answering service will contact the "on call" physician. The on call physician will triage your situation and direct you to the emergency room, urgent care, or a follow up office visit. If you have an immediate concern which cannot wait, please proceed directly to the emergency room.

Rx Refills

- Prescriptions will be refilled at your regularly scheduled office visits. Please bring all of your medications and your drug formulary (provided by your insurance company) to each of your office visits.
- Any phone requests for prescriptions refills will be called to your pharmacy within 24 to 48 hours. If your prescription requires prior authorization by your insurance company, this process will take longer.
- You may be subject to a $25 prescription refill charge at the discretion of the physician.

Insurance and Finances

- Please be advised your insurance is a contract between you and your insurance company. We will be happy to file your insurance; however you are ultimately responsible for payment your bill for all medical services rendered to you. You are also responsible for providing our office with complete and accurate information pertaining to your insurance coverage at each office visit. Please promptly notify us of any changes in your insurance plan.
- Copayments are required at the time services are rendered unless prior arrangements have been made. We accept most major credit cards, cash and checks. We do accept assignment for Medicare, however if you are not covered by a Medicare supplement plan, please be prepared to pay the 20% co-insurance, and payment for non-covered services. Balances that become past due and become subject to collection activity will have an administration fee of 25% added to the balance. Patients in a collections status will be required to pay the balance due before being seen.
- We are participating providers for several managed care insurance plans, and we will adhere to the rules and policies set forth by those plans. You are responsible for all co-payments and any deductibles at the time of your office visit, and prior to any scheduled surgery. Please call your insurance company, prior to your visit, to determine if pre-certification is required for any of your visits or procedures, and notify our staff promptly. Your insurance company may deny your bill for these services, if a pre-certification has not been done.
- Covenant Internal Medicine strongly believes in the value of preventative medicine. Therefore, annual physicals are encouraged for all of our patients. Please check with your insurance company prior to your annual physical to determine if they will pay or be prepared to pay this amount in full.
- For all billing and insurance related questions, please contact our Practice Manager at 864-365-0200.

I understand and agree to the office and financial policies of Covenant Internal Medicine as outlined above: _____

Patient Name: _____
Signature: _____
Date: _____

CCAMB22 Revised 7.26.13

COVENANT
PRIMARY CARE

HIPPA 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.
This notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information, that may identify you and that related to your past, present or future physical or mental health or condition and related health care services.

1. Uses and disclosures of Protected Health Information
Uses and Disclosures of Protected Health Information Your protected health information may be used and disclosed by your physician, our office staff, and others outside of our office 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 physician's practice, and any other use required by law.
Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.
Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain for the hospital admission.
Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of our physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.
We may use or disclose your protected health information in the following situations without your authorization. These situations include: 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: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Worker's Compensation: Inmates: 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 to investigate or determine our compliance with the requirements of Sections 164.500
Other Permitted and Required Uses and Disclosures Will be made only with Your Consent, Authorization or Opportunity to object unless required by law.
Mathias-HIPPA NOTICE OF PRIVACY PRACTICES
You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician or the physician's practice has taken an action in reliance on the use or disclosure indication in the authorization.

Your Rights
Following is a statement of your rights with respect to your protected health information

COVENANT
PRIMARY CARE

You have the right to inspect and copy of your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.
You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care of for notification purposes as described in the Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.
Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use and Healthcare Professional.
You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.
You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.
We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.
Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint. This notice was published and becomes effective on/or before **April 14, 2003.** We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and Privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPPAA Compliance Officer in person or by phone at our Main Phone Number.
Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name: Signature: _____ Date: _____

Do we have your permission to?

Leave a message on your answering machine at home? Yes or no

Leave a message at your place of employment? Yes or no

Discuss your medical condition with a member of your household? Yes or no

If yes, Name: _____ Relationship: _____ Phone: _____

Mathias-HIPPA NOTICE OF PRIVACY PRACTICES

COVENANT
PRIMARY CARE

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize _____ to release healthcare information of the patient named above to:

Name: Bon Secours Covenant Primary Care

Address: 10 Enterprise Blvd. Suite, 111

City: Greenville State: SC Zip Code: 29615

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

☐ All healthcare information

☐ Other: _____

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

☐ Yes ☐ No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: _____ Date Signed: _____

Legal Representative's Signature_____ Relationship to Patient _____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.