SINGLETON HEALTH CENTER

1773 VILLAGE PARK DRIVE
ORANGEBURG, SC 29118

PATIENT REGISTRATION

Patient Information

First Name: _____ MI: _____ Last Name: _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed Sex: ☐ M ☐ F

Home Address: _____ City/State/Zip _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Social Security #: _____ Date of Birth: _____

Race: ☐ Black ☐ Caucasian ☐ Hispanic ☐ Asian ☐ American Indian ☐ Other

Email Address: _____ Preferred Language: _____

Advance Directive: ☐Yes ☐ No If yes, which type _____(you must provide a copy)

Parents/Legal Guardian: _____ Relationship: _____

Insurance Information

Primary Insurance: _____ Policy #: _____

Policy Holder Name: _____ Relationship to Patient: _____

Policy Holder S.S#: _____ Policy Holder Birth Date: _____

Secondary Insurance: _____ Policy #: _____

Policy Holder Name: _____ Relationship to Patient: _____

Policy Holder S.S#: _____ Policy Holder Birth Date: _____

***I ACKNOWLEDGE THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE.

_____ _____

Signature Date

Consent for Treatment

I, suffering from a condition that requires health care services, hereby consent to the rendering of such care, which may include physical examinations, routine visits, minor surgery, and such medical treatment as the physician(s), physician's assistant(s), and nurse practitioner(s), functioning under the direction and supervision of the physician deem necessary. I also give permission to have blood drawn and any tests performed as needed for my care. I understand the results of these tests will be treated with respect and confidentiality and will be made available to my health care provider. If my blood tests positive for any reportable disease, the results will be reported to the state health department (SCDHEC) as required by South Carolina Law.

I understand that Singleton Health Center/ Medical Center of Santee are Rural Health Clinics and that I may be examined by and/or treated by a physician's assistant and/or nurse practitioner as defined by the Regulations of the State Board of Physician's Assistants and who is performing those services that such physician's assistants are legally authorized to perform by the State of South Carolina. I hereby consent to examination by and/or treatment by a physician's assistant operating within any approved written protocols developed by the physicians and/or medical staff of Singleton Health Center/Medical Center of Santee and the physician's assistant(s).

_____

**Signature of Patient or Authorized Person

AUTHORIZATION FOR E- PRESCRIPTION

I, _____ authorize Singleton Health Center and/or Medical Center of Santee,
please print
permission to electronically submit prescriptions on my behalf. I also grant Medical Center of Santee and/or Singleton Health Center permission to access my prescription history from external sources.

_____ _____

**Signature of Patient or Authorized Person Date

MEDICATION FORM

Name: _____ Date of Birth: _____

IMMUNIZATION RECORD (Print date and year of last vaccine)

Tetanus _____ Flu Vaccine: _____

Pneumonia Vaccine: _____ Hepatitis: _____

Other: _____

ALLERGIES:

Allergic To	Describe Reaction

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING: (Prescription or over-the-counter; examples: aspirin, antacids, vitamins, ginseng)

Date Started	Medication and Dosage	Directions	Date Stopped	Reason for taking medication

GENERAL MEDICAL HISTORY

Patient's Name: _____ Date: _____

Please answer the following question as specific as possible:

Cardiovascular (heart, arteries, veins)

Hypertension	☐ YES ☐ NO
Heart Murmur	☐ YES ☐ NO
Heart Attack	☐ YES ☐ NO
Valve Problems	☐ YES ☐ NO
Varicose Veins	☐ YES ☐ NO
Stroke	☐ YES ☐ NO

Other: _____

Respiratory (lungs)

Asthma	☐ YES ☐ NO
Emphysema	☐ YES ☐ NO
Tuberculosis	☐ YES ☐ NO

Other: _____

Eye

Cataracts	☐ YES ☐ NO
Glaucoma	☐ YES ☐ NO

Other: _____

Psychiatry

Neurosis	☐ YES ☐ NO
Depression	☐ YES ☐ NO
Schizophrenia	☐ YES ☐ NO

Other: _____

Musculoskeletal (muscles, joints)

Arthritis	☐ YES ☐ NO
Back Problem	☐ YES ☐ NO
Hip/Knee Replacement	☐ YES ☐ NO
Bone Fractures	☐ YES ☐ NO

Other: _____

Genitourinary (kidney, bladder)

Kidney Stones	☐ YES ☐ NO
Urinary Tract	☐ YES ☐ NO

Other: _____

Women Only

Fibroid Tumor	☐ YES ☐ NO
Pelvic Inflammatory Disease	☐ YES ☐ NO

Gastrointestinal (stomach, liver, intestines)

Ulcer	☐ YES ☐ NO
Colitis	☐ YES ☐ NO
Gallstones	☐ YES ☐ NO
Reflux/Heartburn	☐ YES ☐ NO
Cirrhosis/Liver	☐ YES ☐ NO
Hepatitis	☐ YES ☐ NO

Other: _____

Neurological (brain, nerves)

Migraines	☐ YES ☐ NO
Epilepsy	☐ YES ☐ NO
Sleep Problems	☐ YES ☐ NO

Other: _____

Genitourinary (kidney, bladder)

Kidney Stones	☐ YES ☐ NO
Urinary Tract	☐ YES ☐ NO

Other: _____

Hematologic (blood, cancer)

Bleeding problem	☐ YES ☐ NO
Cancer	☐ YES ☐ NO

If yes where:

Other: _____

Other

HIV or AIDS	☐ YES ☐ NO
Obesity	☐ YES ☐ NO
Alcoholism	☐ YES ☐ NO
Drug Abuse	☐ YES ☐ NO

Other: _____

Endocrine (hormones)

Diabetes	☐ YES ☐ NO

Other: _____

Men only

Enlarged Prostate	☐ YES ☐ NO

Please allow us to photocopy your insurance card (s) and Identification Card

INSURANCE INFORMATION AUTHORIZATION

Payment for services rendered is to be made as follows:
I authorize payments of insurance benefits be made to, Singleton Health Center/ Medical Center of Santee, for any services or items furnished to me by the physicians or suppliers. I authorize the practice to release to the Health Care Financing Administration, my insurance carrier and/or its agents, appropriate information needed to determine these benefits or the benefits payable to related services, in accordance with HIPPA guidelines. Release of other information requires specific release authorization. I am financially responsible for appropriate deductibles, copayments, co-insurances and non- covered services or items. If this account has to be turned over to an attorney/collection agency due to delinquency or non- payment, I will be responsible for all costs of collection including the court costs and reasonable attorney/collection fees.

_____

**Signature of Beneficiary or Authorized Person

To whom may we, as your Healthcare Providers, release information about your Medical condition (s) and/or inform of emergencies;

Emergency Contact: _____ Phone#: _____ Relation to Patient: _____

Name of Individual 1: _____ Phone#: _____ Relation to Patient: _____

Name of Individual 2: _____ Phone#: _____ Relation to Patient: _____

Acknowledgement of Receipt of Notice of Privacy Practices

I have received a copy of the Notice of Privacy Practices

_____

**Signature of Patient or Authorized Person

SINGLETON HEALTH CENTER
1773 VILLAGE PARK DRIVE ORANGEBURG, SC 29118
PHONE: 803 535 3600 FAX: 803-531-7310

Medical Record Information Release

I _____ authorize you to copy this form to release any information in my records, files, etc., to Singleton Health Center/Medical Center of Santee. This authorization includes, but is not limited to information relating to employment, physical and mental health history, financial or other individual agency, or institution, whether public or private, concerning myself and/or dependent(s).

_____		_____	
Name	Dob	Name	Dob
_____		_____	
Name	Dob	Name	Dob
_____		_____	
Name	Dob	Name	Dob

You are hereby absolved of any responsibility for disclosure of any information pursuant to this authorization and any liability is hereby waived. It is also understood that this information will be maintained by Singleton Health Center/Medical Center Santee in a confidential manner.

_____ _____

****Signature of Patient or Authorized Person** **Date**

*** This authorization is valid for two (2) years, unless a medical/legal status has altered patient or guardian authority to make medical decisions. A directive/decree must be recorded and place in patient's records to void this document.

SINGLETON HEALTH CENTER

MEDICAL CENTER of SANTEE

No Show Policy

Singleton Health Center/Medical Center of Santee defines a No Show as any scheduled appointment in which the patient either:

- Does not arrive for the scheduled appointment
- Cancels less than 24 hours before the scheduled appointment without a valid reason
- Arrives more than 20 minutes late for a scheduled appointment

Impact of No Shows: No shows have a significant adverse impact on our practice and the healthcare we strive to provide for our patients. When a no show occurs it:

- Potentially jeopardizes the health of the patient who is a no show
- Is unnecessarily frustrating as well as extremely unfair to the patients who could have taken the appointment slot
- Disrespects the time of the provider and the entire practice staff

How to Avoid a No Show:

1. Confirm your appointment
   - Singleton Health Center will attempt to contact you 24 hours prior to your scheduled appointment. An automated system will call the phone number listed in your patient record. Please confirm or cancel the appointment when prompted by the automated instructions.
2. Arrive early
   - Arriving early ensures you are not late. Additionally, it allows you sufficient time to discuss any questions regarding billing, insurance, etc. you may have with the appropriate staff member.
3. Give 24 hours cancellation notice
   - If you are unable to make your scheduled appointment, please notify the office at least 24 hours in advance. This provides our office with the necessary time to reschedule your appointment, if applicable. Additionally, it provides our office with the opportunity to schedule another patient in the newly available time slot.

Consequences of Frequent No Shows:

3 or more consecutive no shows will result in a patient's inability to schedule an office visit for 6 months. These patients will be seen on an urgent/emergency basis – to be determined by their Care Team. This means only Same Day Appointment will be available unless the provider informs the front desk to schedule an office visit.

I have read and understand the Singleton Health Center/Medical Center of Santee No Show Policy as described above.

_____ _____

Patient's Printed Name Date

_____

Patient's Signature

SINGLETON HEALTH CENTER

MEDICAL CENTER of SANTEE

Patient –Centered Medical Home

Our responsibility to you:

- Each patient has an ongoing relationship with a personal clinician trained to provide first contact, continuous, and comprehensive care.
- The personal clinician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of members.
- The personal clinician is responsible for providing for all the patient's health care needs, including behavioral health, or taking responsibility for appropriately arranging care with other professionals.
- Care is coordinated and/or integrated across all elements of the complex health care system and our community.
- Quality and safety are hallmarks of the medical home, supporting the attainment of optimal, patient-centered outcomes. Personal clinicians accept accountability for continuous quality improvement through evidence-based medicine.
- Enhanced access to care is available through systems such as open scheduling, expanded hours, and new options for communication between patients, their personal physician, and practice staff.
- Provide instructions for the following: obtaining care as well as clinical advice during and after office hours, transferring medical records, information for the uninsured to gain coverage and, payment options for those experiencing financial hardship. Additionally, a point of contact for the office will also be provided.
- Regardless of source of payment, all patients will be given the same access opportunity to see their provider/clinical care team.

Responsibility as our patient:

- Provide complete medical history and information about care obtained from other healthcare facilities
- Take medicines as prescribed, keep all scheduled appointments, ask any questions, and tell us when you do not understand something.
- Inform us if you were recently treated at the hospital.
- Follow the care plan establish between you and your provider.
- Contact the practice at least 24 hours prior to your appointment to reschedule or cancel your appointments. A failure to reschedule or cancel an appointment results in a "No Show." 5 or more consecutive reschedules and/or no shows will result in the implementation of our No Show Policy. The No Show Policy is included in your Patient Registration packet. Additionally, it is posted in the patient waiting room and available upon request.

_____ _____

Patient Printed Name Date

_____

Patient Signature

SCHIEx Notice of Participation

South Carolina Health Information Exchange (SCHIEx EXCHANGE) makes it possible for your doctor to share your medical history, including medications, allergies, diagnoses, and procedures, with other doctors and health care providers involved in your care. It is a safe and secure network that makes sure your personal health information is available to your doctors and other health care providers when and where it is needed. SCHIEx does not keep or store your personal health information. By allowing your doctors and other health care providers to use and share your personal health information through SCHIEx EXCHANGE:

- Your doctor will have more information available to make even more informed health care decisions at the time of your appointment.
- Your doctor may know better which tests or services you have already received, so you can avoid repeated or needless tests or services.
- Your doctors and other health care providers can better coordinate your health care. This can save you time and money by avoiding repeated or needless tests and doctor visits, paperwork, or appointment delays.
- Your health information is available when and where it is needed, whether it is a routine office visit or in case of an emergency.

HOW YOUR ELECTRONIC HEALTH INFORMATION MAY BE USED OR SHARED
Your privacy and your personal health information are protected by federal and state law. Those federal and state laws also govern the way your personal and electronic health information is used or shared through SCHIEx.

SCHIEx EXCHANGE members may include health care providers licensed in the State of South Carolina, including medical doctors, dentists, chiropractors, optometrists, podiatrists, pharmacists, physician assistants, and nurse practitioners. SCHIEx EXCHANGE members also may include organizations such as hospitals, ambulatory surgical facilities, home health agencies, pharmacies, case management providers, telemonitoring providers, health information exchanges and organizations within which eligible individuals practice. We may submit information as required by law, including but not limited to: immunization data, quality reporting data, and communicable disease data to a state or federal agency.

We will use our best efforts to make all of your electronic health information available through SCHIEx EXCHANGE. However, we cannot guarantee that all of your personal health information will be available at that time. You are required to sign this form, acknowledging that you have received this SCHIEx EXCHANGE Notice of Participation. If you choose to allow your providers to share your electronic health information, you don't need to do anything else.

__ I wish to participate. __ I wish ***not*** to participate.

_____ **Print Name** _____ **Signature**

_____ **Date of Birth** _____ **Today's Date**

For Office Use Only

_____ _____

Signature of Staff Member Executing Opt Out Date Opt Out Executed

Notice of Privacy Practices HIPAA Statement

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.

Who Will Follow This Notice:

This Notice of Privacy Practices applies to the Hospital and its employees, volunteers, students and trainees. This Notice also applies to other health care and service providers that provide care or services at the Hospital, or for its patients, in that, as a condition to providing services at the Hospital, such providers must agree to comply with all Hospital policies, including its policies relating to patient privacy. This Notice, however, only details the privacy policies of the Hospital and does not govern the independent practices or operations of health care and service providers, for services provided independent of the Hospital.

This Notice will also be followed by other affiliated entities within Singleton Health Center/ Medical Center of Santee with whom we share information.

Our Pledge Regarding Medical Information

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive at the Hospital. We need this record to provide you with quality care and to comply with certain legal requirements. This Notice applies to all of the records of your care generated by the Hospital, whether made by Hospital personnel or your personal doctor or other practitioners involved in your care. Your personal doctor may have different policies or Notices regarding the doctor's use and disclosure of your medical information created in the doctor's office or clinic.

This Notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

We are required by law to make sure that medical information that identifies you is kept private give you this Notice of our legal duties and privacy practices with respect to medical information about you and follow the terms of the Notice that is currently in effect.

How we may use and disclose medical information about you

The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Treatment

We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, health care students, clergy, or others who are involved in your care.

For Payment

We may use and disclose medical information about you so that the treatment and services you receive at our facility may be billed to and payment may be collected from you, an insurance company or a third party. 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 medical information about you for the practice operations. These uses and disclosures are necessary to run the Facility and make sure that all of our patients receive quality care. For example, we may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you or we or our designee may send you a patient satisfaction survey. We may also combine medical information about many facility patients to decide what additional services the Practice should offer, what services are not needed, and whether certain new treatments are effective. We may also disclose information to doctors, nurses, technicians, health care students, and other medical facilities personnel for review and learning purposes. We may also combine the medical information we have with medical information from other practices to compare how we are doing and see where we can make improvements in the care and services we offer. We may remove information that identifies you from this set of medical information so others may use it to study health care and health care delivery without learning who the specific patients are.

Appointment Reminders

We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or medical care for either facility.

Individuals Involved in Your Care or Payment for Your Care

We may release medical information about you to a care giver who may be a friend or family member. We may also give information to someone who helps pay for your care.

Lawsuits and Disputes

If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute.

Your Rights Regarding Medical Information About You

Right to Inspect and Copy:

You have the following rights regarding medical information we maintain about you:
To inspect and copy medical information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include mental health information, under the federal law.