GREENVILLE HEALTH SYSTEM

Patient Information

(Please print)

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

Sex: ☐ Male ☐ Female

Date of Birth: _____ SS#: _____ Ethnicity: Hispanic/Latino ☐
Month/Day/Complete Year Non-Hispanic/Non-Latino ☐
Refuse/Decline ☐

Primary Care Physician: _____

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: _____ Home Phone: ( ) _____ Cell Phone: ( ) _____

Preferred language: _____ E-mail: _____

Veteran: ___Yes ___No ___Unknown Religion: _____

Guarantor Information *(If guarantor is Self, skip to Emergency Contact)*
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*

Home Phone: ( ) _____

Date of Birth: _____ SS#: _____ Cell 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: _____ Home Phone: ( ) _____

Patient Relation to Emergency Contact _____ Cell Phone: ( ) _____

Secondary Contact Name: _____ Home Phone: ( ) _____

Patient Relation to Emergency Contact _____ Cell Phone: ( ) _____

Employment

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*

Date of Birth: _____
Month / Day / Complete Year

SS#: _____

Home Address: _____ City: _____ State: _____ Zip: _____
(if different from patient)

Home Phone: _____ Cell 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*

Date of Birth: _____
Month / Day / Complete Year

SS#: _____

Home Address: _____ City: _____ State: _____ Zip: _____
(if different from patient)

Home Phone: _____ Cell 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. And, skip to Authorization (below).**

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

Subscriber: This is the person who carries the insurance. If Subscriber is the Patient, skip to Insurance Co Name field.

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: _____ Home Phone:_____

Employer: _____ Work Phone: _____ Ext._____

Insurance Co. Name: _____ **Phone:** _____

Policy/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

SUBSCRIBER: This is the person who carries the insurance. If Subscriber is the Patient, skip to Insurance Co Name field.

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: _____ Home Phone:_____

Employer: _____ Work Phone: _____ Ext._____

Insurance Co. Name: _____ **Phone:** _____

Policy/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**

Authorization

I authorize medical evaluation & treatment, and release of information for insurance/medical purposes concerning my illness and treatment. I hereby authorize payment from my insurance company to the Greenville Health System for services rendered. I will be responsible for any amount not covered by my insurance.

Signature of Patient/Guardian/Guarantor: _____ **Date:**_____

GREENVILLE HEALTH SYSTEM

Medications, Allergies and Immunizations

Today's Date _____ Patient Name_____ DOB _____

Please Bring All Medications to Your Visit

Prescription Medications –List all medications you are presently taking

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

Non-Prescription Medications –List all medications you are presently taking

	Name and Dose	How Often	Date Started
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			

Current Pharmacy

Name and Location _____ Phone Number _____

Preferred _____

Other _____

GREENVILLE HEALTH SYSTEM

Today's Date _____ Patient Name_____ DOB _____

Allergies – list all allergies or unusual reactions you have to medications, foods, dyes latex and other agents.

Allergy	Reaction
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.

	Date Received	Others	Date Received
❑ Tetanus			
❑ Flu			
❑ Pneumonia			
❑ HPV			
❑ Hepatitis B			

Screenings – List the most recent date and doctor for the following screenings:

	Date	Doctor/Practice/Facility Name
Complete Medical Physical		
Full panel of lab work		
Cholesterol (lipid) screening		
Chest X-ray		
Treadmill Stress Test		
Other heart tests		
Colonoscopy		
Mammogram		
Bone Density		

GREENVILLE HEALTH SYSTEM

Today's Date _____ Patient Name_____ DOB _____

Hospitalization & Surgical History – List all hospital admissions and operations you have had.

	Reason for Hospitalization/Surgery	Year
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.

	Relationship	Age at onset
❑ 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:		

AUTHORIZATION FOR DISCLOSURE OF MEDICAL INFORMATION

THE INFORMATION PROVIDED IN THIS FORM WILL BE RELIED UPON BY ALL HEALTH CARE PROVIDERS OF GREENVILLE HEALTH SYSTEM UNLESS REVOKED OR MODIFIED BY THE PATIENT IN WRITING.

Patient Name (PRINT) _____

(For Office Use Only)
MRN_____

DOB _____

Authorization for Disclosure of Medical Information: The privacy of your medical information is important. We will discuss your medical condition with person(s) you designate.

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHOM? (*Check and complete one*)

☐ The following family members or other individuals may receive information regarding my medical condition:
*Print first and last name(s)*_____
_____

OR

☐ Any family member or other individual inquiring about my medical condition may receive information from my provider, EXCEPT the following individuals: *Print first and last name(s)*_____
_____

You may revoke/cancel or modify/change the above designation, but the revocation or modification must be in writing.

NOTE: This designation does not give the above named individuals the right to make health care decisions for you. If at any time you are unable to consent to care or treatment, we will follow the procedure set forth in the South Carolina Adult Health Care Consent Act.

Confidential Communication: Please provide phone number(s) where we can reach you:
☐ Home:_____ ☐ Work:_____ ☐ Cell Phone:_____ ☐ Other_____

Messages: A request for return calls may be left on the following answering machine or voice mail: (*Check all that apply*)
☐ Home ☐ Work ☐ Cell Phone ☐ I do not authorize

I authorize my medical information to be left on the following answering machine or voice mail: (*Check all that apply*)
☐ Home ☐ Work ☐ Cell Phone ☐ I do not authorize

If we are unable to reach you or leave a message at the above phone number(s), please indicate with whom we may leave a message for you to call our facility.
Name _____ Phone Number _____
Name_____ Phone Number _____
Note: *An automated appointment reminder system may call the number listed in our data base.*

Signature: I hereby authorize the disclosure of my medical condition and information as described above.
Patient/Patient's Representative Signature:_____ Date: _____Time:_____
PRINT Name (if Patient's Representative): _____
Relationship to Patient (if Patient's Representative):_____

GHS Representative:_____Date: _____ Time:_____

GREENVILLE HEALTH SYSTEM

Release of Information Authorization

Patient Name: _____ Date of Birth: _____

Last 4 Digits of SSN: _____ Phone #: _____ e-mail address: _____

NOTE: All items, 1 through 6 must be completed, along with signature and date

1.) Release Records To: (**Where** do you want the information sent? **Who** may have the information?)	Name of individual, healthcare provider/hospital/practice: _____ Address: _____ City: _____ State: _____ Zip Code: _____ Day Phone Number: _____ Fax Number: _____		
2.) Obtain Records From: (**Who** has the information you want released?) Please list the specific Hospital and / or clinic.	Name of Organization/Hospital or Medical Practice: _____ Address: _____ City: _____ State: _____ Zip Code: _____ Day Phone Number: _____ Fax Number: _____		
3.) Release Instructions: (**How** do you want the information?)	Release Method / Format Requested: (check one) ☐ Mail ☐ My Chart / Epic ☐ Fax (To healthcare provider ONLY) ☐ Electronic ☐ Other _____		
4.) Purpose of Release: (**Why** is it needed?)	☐ Continuing Care ☐ Legal ☐ Patient Request ☐ Military ☐ Insurance ☐ Disability ☐ School ☐ Other _____ I understand that fees for copies of medical records/images and postage fees may be charged as provided by S.C. Law.		
5.) Treatment Date(s): (**When** were you seen?)	☐ Treatment dates from _____ to _____ (please be specific) **OR** ☐ All Treatment Dates		
6.) Information to be Released: (**What** do you want sent or released? Check the appropriate box.)	☐ ENTIRE RECORD ☐ Immunization Records ☐ Medication List ☐ Physician Progress / Visit Notes	☐ Abstract Information History & Physical, Consults, Lab & Radiology Reports, Discharge Summary, Operative/ Procedure Reports,. Emergency Department Reports, and Occupational / Physical Therapy Reports.	☐ Psychotherapy ☐ Test Results ☐ Demographics ☐ Other: _____

I understand this information may include reference to psychiatric / psychological care, sexual assault, drug abuse, alcohol abuse, and/or results of tests for all infectious diseases including HIV / AIDS.

I understand that I have a right to cancel / revoke this authorization at any time. I understand that if I cancel / revoke this authorization I must do so in writing and present my written cancellation / revocation to the Health Information Services Department (Medical Records). I understand that the cancellation / revocation will not apply to information that has already been released in response to this authorization, as stated in the Notice of Privacy Practice. Unless otherwise canceled / revoked. This authorization will expire / end one year from this date or _____.

I understand that authorizing the disclosure of protected health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to receive treatment. I understand I may review and / or copy the information to be disclosed as provided in 45 CFR 164.524. I understand that any disclosure of information carries with it the possibility of unauthorized disclosure by the person / organization receiving this information. I understand I have a right to a copy of this authorization.

Proof of identity may be required, attaching a copy of your photo ID is recommended. (NOTE: Allow 30 days for processing according to Federal regulation.)

_____ _____

Printed Name of Patient or Legal Guardian / Representative — Date

x_____ _____

Signature of Patient or Legal Guardian Representative — Relationship to Patient, if Signed by Legal Guardian

Document(s) of patient representative's authority must be attached if patient is not signing.

When requesting GHS to send records, return this form to:
255 Enterprise Blvd., Suite 120, Greenville, S.C. 29615; Phone (864) 454-4600 Fax (864) 454-4654

GHS 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.

GREENVILLE HEALTH SYSTEM

Greenville Health System (GHS) makes every effort to keep your health information private. Each time you visit a GHS facility (doctor's office, clinic, hospital or outpatient center), 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 of Privacy Practices* (hereafter referred to as Notice) applies to all health records produced at GHS, 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.

This Notice applies to all GHS sites, including offices of physicians employed by GHS and to all physicians and other healthcare providers who provide you with healthcare services at any GHS site through the Greenville Health System Organized Health Care Arrangement (please see the end of this document for a list of major GHS facilities). It does not apply to care you receive from physicians or other healthcare providers at their private offices (unless the physician or other healthcare provider is employed by GHS) or at any non-GHS site.

The law requires GHS to do the following:

- ***Keep your health record private***
- ***Describe our legal duties and privacy obligations related to your health information***
- ***Follow the current Notice of Privacy Practices***
- ***Notify you if there is a breach of your unsecured personal health information (PHI)***

We reserve the right to change the practices and terms of this Notice, and the changes will be effective for the information we already have about you as well as any information we receive in the future. The Notice will list the effective date in the top right-hand corner of the first page.

Each time you register at or are admitted to GHS as an inpatient or outpatient, you may have a copy of the Notice. We will post it in our facilities and on our website (**www.ghs.org**). You also may call our Privacy Office at **(864) 797-7755** 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, specialists, technicians, students of affiliated healthcare programs, volunteers or other staff who care for you. Such people may share information about you to coordinate your needs, such as lab work or prescription drugs.

Here is how your health record might be used for treatment reasons:

- A doctor treating your broken leg may need to know if you have diabetes, which slows healing. Also, the doctor may need to tell the dietitian that you have diabetes to arrange for special meals.
- We may send your record to specialists your doctors here may want to consult.
- Your record may be sent to a doctor to whom you have been referred.
- We would share your record with a facility you are being transferred to or one that you are considering transfer to once you leave GHS.
- 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:

- We may call your health plan for pre-approval of a service to determine whether your treatment will be covered.
- We may give your health plan details about your care, so it will pay us or reimburse you. For example, if you have a broken leg, we may need to give your health plan(s) information about your condition and supplies used.
- We may use and disclose your health information to other providers so they may bill and collect payment for treatment and services they provided to you.
- We may share your health information with billing and collection departments or agencies, insurance companies and health plans to collect payment for services, departments that review the appropriateness of the care provided and the costs associated with that care, and to consumer reporting agencies (for instance, credit bureaus).

Healthcare Operations

We may use and release your record to support our business functions (such as administrative, financial and legal activities). These uses and disclosures are needed to run the hospital, 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 healthcare operations:

- Reviewing and improving the quality, efficiency, and cost of care that we provide to you and other patients
- Evaluating the skills, qualifications, and performance of healthcare providers taking care of you
- Providing training programs for students, trainees, healthcare providers, or non-healthcare professionals (for example, billing clerks) to help them practice or improve their skills

Facility Directory

We may include certain facts about you in our directory while you are a patient at a GHS hospital, clinic or doctor's office. These facts may include your name, location, general condition (such as fair or stable) and religious affiliation. They also may be shared with those who ask for you by name (except for religious affiliation). Your affiliation may be given to clergy members—even if they don't ask for you by name—so family members, friends and clergy can visit you or know how you are doing. However, if you do not want your information listed in the hospital directory, please notify Registration when you arrive or call the facility's Admitting Office.

People Involved in Your Care or Payment for Your Care

GHS health experts may tell a family member, friend, or other person you identify or who is involved in your care or payment for your care details about you that relate to that person's involvement in your care. However, GHS respects your right to choose not to have your information shared. When you arrive at a GHS facility, Registration will ask you to complete a form indicating with whom we may share your information (you are not required to designate any individuals). If you cannot physically or mentally agree or object to a disclosure, we may supply information where necessary. We also 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 GHS provide some services related to treatment, payment and business operations. For example, we may use a copy service to make copies of your medical record. When we hire companies to perform these services, we may disclose your health information to these companies so that they can perform the job we have asked them to do. We have a written agreement 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.

Research

Under certain circumstances, we may use and disclose health information about you for research purposes. All research projects, however, are subject to a special approval process. Before we use or disclose medical information for research, the project will have been approved through this research approval process. We may, however, use health information about you in preparing to conduct a research project, for example, to look for patients with specific needs.

Fundraising Events

GHS is a nonprofit health system that relies on generous support from patients and families to continue vital healthcare, research and education operations. We may use your demographic information such as name, address and birthday to contact you regarding fundraising opportunities. We also may use the dates you received treatment or services, department of service, outcomes information and treating information. You have the right to elect not to receive fundraising communications. Please contact us at **(864) 797-7749** (Office of Philanthropy & Partnership) if you wish to have your name removed from the list to receive fundraising requests supporting GHS in the future. Your decision not to receive fundraising communications will have no impact on your ability to receive healthcare services at any GHS facility.

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
- 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.

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 the following:

- To prevent or control disease, injury or disability
- To report births and deaths
- To report adverse events, product defects or problems, or drug reactions
- To note product recalls
- To notify a person who may have been exposed to a disease or may be at risk for getting or spreading one

To Avert a Serious Threat to Health or Safety and to Report Abuse

We may disclose your health information to a government agent if we believe you have been the victim of abuse, neglect or domestic violence. We also may disclose your information where necessary to protect your health and safety or the health and safety of the public or another person. Disclosures are made only to those people able to help prevent or reduce the threat.

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 also may 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 also may 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:

- In response to a court order, subpoena, warrant, summons or similar legal process
- To identify or locate a suspect, fugitive, witness or missing person
- 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

- In case of a death we believe may be the result of criminal conduct
- In response to criminal conduct at the hospital
- 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 in either an electronic or paper form (this information often includes medical and billing records but, under federal law, excludes psychotherapy notes, which are maintained exclusively at our Marshall I. Pickens Hospital location).

To do so, write to the Medical Records Department of GHS Health Information Management at the address listed on the back cover of this Notice. There may be a fee for costs involving copying, mailing and related supplies. We will respond to you within 30 days of receiving your written request if your record has been maintained in our facility. If your record has been maintained in a secure off-campus location, we will respond within 45 days.

We may deny your request to inspect and copy in certain cases. If we deny your request, we will respond to you in writing, stating why we will not grant your request and describing any rights you may have to request a review of our denial. Another licensed healthcare professional chosen by GHS will examine your request. The reviewer will not be the person who denied your request. GHS 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 to the information. You have the right to request a change or addition for as long as the record is kept by GHS.

Request your change in writing to the Medical Records Department of GHS Health Information Management at the address listed on the back cover of this Notice. You must give a reason that supports your request. To obtain a form to amend, please call the Release of Medical Information Office in Medical Records at **(864) 454-4600**.

We may deny your request if it is not in writing or does not include a reason to support the request. We also may deny a request to modify a medical record in these cases:

- The current information is accurate and complete.
- It is not part of the medical information kept by or for GHS.
- It is not part of what you would be allowed to view and copy.
- 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 and maintain your request to modify in your medical record.

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, healthcare operations or national security). We are required to respond to your request within 60 days.

We are required to provide a listing of all disclosures except the following:

- For your treatment
- For billing and collection of payment for your treatment
- For our healthcare operations
- Occurring as a byproduct of permitted uses and disclosures
- Made to or requested by you or that you authorized
- Made to individuals involved in your care, for directory or notification purposes, or for disaster relief purposes
- Allowed by law when the use and/or disclosure relate to certain specialized government functions or relates to correctional institutions and in other law enforcement custodial situations
- As part of a limited set of information that does not contain certain information which would identify you

The list will include the date of the disclosure, the name (and address, if available) of the person or organization receiving the information, a brief description of the information disclosed and the purpose of the disclosure. Request this list in writing to Medical Information at the appropriate address listed on the back cover of this Notice. Your request must state a period of time, which may not be longer than six years before the date of your request.

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 to your family about a surgery that you had.

You have the right to request that we not disclose to your health plan health information or services for which you paid out of pocket before the performance of those services.

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 an employee at your GHS point of admission or registration. Note (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 at work.

To request confidential communications, submit a Restriction of Information Agreement Form to an employee at your GHS point of admission or registration. 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 your GHS point of admission or the Privacy Office at **(864) 797-7755**. You also may get a copy from our website, **www.ghs.org**.

Complaints

If you believe your privacy has been violated, you may file a complaint with GHS or with the Secretary of the Department of Health and Human Services. To file a complaint with GHS, call our Privacy Office at **(864) 797-7755** or Service Excellence Department at **(864) 455-7975**.

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.)*

To request a copy of, review of or amendment to your health record, please write to ...

GHS Health Information Management
Medical Records Department
255 Enterprise Blvd., Ste. 120
Greenville, SC 29615

GHS Major Facilities

The Cottages at Brushy Creek
101 Cottage Creek Circle
Greer, SC 29650

Cottingham Hospice House
390 Keowee School Road
Seneca, SC 29672

Cross Creek Surgery Center
9 Doctors Drive
Greenville, SC 29605

Greenville Memorial Hospital
701 Grove Road
Greenville, SC 29605

Greer Memorial Hospital
830 S. Buncombe Road
Greer, SC 29650

Hillcrest Memorial Hospital
729 S.E. Main St.
Simpsonville, SC 29681

Hospice of the Foothills
390 Keowee School Road
Seneca, SC 29672

Laurens County Memorial Hospital
22725 U.S. Hwy. 76 East
Clinton, SC 29325

Lila Doyle Nursing Center
101 Lila Doyle Drive
Seneca, SC 29672

Marshall I. Pickens Hospital
701 Grove Road
Greenville, SC 29605

Medical Center Clinics
701 Grove Road
Greenville, SC 29605

North Greenville Hospital–Long Term Acute Care
807 N. Main St.
Travelers Rest, SC 29690

Oconee Memorial Hospital
298 Memorial Drive
Seneca, SC 29672

Patewood Memorial Hospital
175 Patewood Drive
Greenville, SC 29615

Roger C. Peace Rehabilitation Hospital
701 Grove Road
Greenville, SC 29605

14-21407874
10/14

A37575

GREENVILLE HEALTH SYSTEM

Financial Policy

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 to the patient by Greenville Health System, GHS Partners in Health, and the various entities and providers affiliated with them each individually and collectively referred to as Greenville Health System or GHS.

Payment for Service: Each office will inform you of co-pay and deductible amounts at check in or check out. These amounts are 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 $25.00
- 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 canceled 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 during normal office hours.

Payment for Services Provided by Certain 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 Health 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.