Golden Corner Family Practice

1205 North Hwy 11 West Union, SC 29696 Phone: 864-638-5402 Fax: 864-638-6126

Patient Information

(Please print)

Full Legal Name: _____

Last First Middle

Date of Birth: _____ Social Security #: _____ Sex: Male ☐ Female ☐

Ethnicity: Hispanic/Latino ☐ Non-Hispanic/ Non-Latino ☐ Refuse/Decline ☐

Marital Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other: _____

Race: _____Preferred Language: _____

Email: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Employment Information

Patient Employer: _____ Work Phone: _____ Ext: _____

Employment Status: Full-Time ☐ Part-Time ☐ Self Employed ☐ Active Military ☐ Retired ☐

Disabled ☐ Not Employed ☐ Student: Full-Time ☐ Student: Part-Time ☐

Emergency Contact Information

Primary Emergency Contact: _____ Phone Number: _____

Relationship to Patient: _____

Secondary Emergency Contact: _____ Phone Number: _____

Relationship to Patient: _____

Parent/Guardian or Spouse Information

Full Legal Name: _____

Last First Middle

Date of Birth: _____ Social Security #: _____ Phone Number: _____

Home Address: _____ City: _____ State: _____ Zip: _____

(If different from patient)

Employer: _____ Work Phone: _____ Ext: _____

Primary Insurance Information: **Subscriber:** This is the person who carries the insurance

Subscriber's Name on Card: _____ Subscriber's DOB: _____

Patient Relationship to Subscriber: _____

Insurance Name: _____

Policy Number: _____ Group Number: _____

Secondary Insurance Information

Subscriber's Name on Card: _____ Subscriber's DOB: _____

Patient Relationship to Subscriber: _____

Insurance Name: _____

Policy Number: _____ Group Number: _____

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 Golden Corner Family Practice for services rendered. I will be responsible for any amount not covered by my insurance.

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

Golden Corner Family Practice

Health History Questionnaire

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name: _____ DOB: _____

Previous or Referring Doctor: _____ Date of Last Physical Exam: _____
Do you have any advance directives? (DNR, Living will, Custody papers, medical power of attorney)
List: _____

Personal Health History

Childhood Illness: Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio ☐

Immunizations: Please check all that apply.

☐ Tetanus: Date: _____ Location Received: _____
☐ Hepatitis: Date: _____ Location Received: _____
☐ Influenza: Date: _____ Location Received: _____
☐ Pneumonia: Date: _____ Location Received: _____
☐ Chickenpox: Date: _____ Location Received: _____
☐ MMR (measles, mumps, and rubella): Date: _____ Location received: _____

List any medical problems that other doctors have diagnosed: _____
_____
_____

Surgeries: Please List

Surgery	Year	Hospital

Other Hospitalizations

Reason	Year	Hospital

Have you ever had a blood transfusion? Yes ☐ No ☐

Allergies: (medications, food, insects, animals, dyes, latex, etc)

_____
_____

List all prescribed medication and over the counter medication (vitamins, inhalers)

Name of Medication	Strength	Frequency Taken

Health Habits and Personal Safety:

All questions contained in this questionnaire are optional and will be kept strictly confidential.

Exercise	❑ Sedentary(No exercise)			
	❑ Mild exercise(climb stairs, walk, golf)			
	❑ Occasional vigorous exercise(work or recreation, less than 4x/week for 30mins			
	❑ Regular vigorous exercise(work or recreation, 4x/week for 30mins)			
Diet	Are you dieting?		Yes	No
	If yes, are you on a physician prescribed medical diet?		Yes	No
	Average number of meals you eat in a day?			
	Salt intake	Hi	Med	Low
	Fat Intake	Hi	Med	Low
Caffeine	None	Coffee	Tea	Cola
	Number of cups/cans per day?			
Alcohol	Do you drink alcohol?		Yes	No
	If yes, what kind?			
	How many drinks per week?			
	Are you concerned about the amount you drink?		Yes	No
	Have you considered stopping?		Yes	No
	Have you ever experienced blackouts		Yes	No
	Are you prone to “binge”drinking?		Yes	No
	Do you drive after drinking?		Yes	No
Tobacco	Do you use tobacco?		Yes	No
	Cigarettes: _____	Chew: ____	Pipe: _____	Cigars:_____
	Number of Years: _____	Years Quit: _____		
Drugs	Do you currently use recreational or street drugs?		Yes	No
	Have you ever given yourself street drugs with a needle?		Yes	No

Sex	Are you sexually active?	Yes	No
	If yes, are you trying for a pregnancy?	Yes	No
	If not trying for a pregnancy, list contraceptive or barrier method used:		
	Any discomfort with intercourse?	Yes	No
	Illness related to the Human Immunodeficiency Virus(HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?	Yes	No
Personal Safety	Do you live alone?	Yes	No
	Do you have frequent falls?	Yes	No
	Do you have vision or hearing loss?	Yes	No
	Physical and/or mental abuse has also become major public health issues in the country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?	Yes	No

Mental Health

Is stress a major problem for you?	Yes	No
Do you feel depressed?	Yes	No
Do you panic when stressed?	Yes	No
Do you have problems with eating or your appetite?	Yes	No
Do you cry frequently?	Yes	No
Have you ever attempted suicide?	Yes	No
Have you ever seriously thought about hurting yourself?	Yes	No
Do you have trouble sleeping?	Yes	No
Have you ever been to a counselor?	Yes	No

Family Health History: Please list all significant health problems with any immediate family.

_____

_____

_____

_____

Women Only		
Age at onset of menstruation?		
Period every _____ days		
Heavy periods, irregularity, spotting, pain, or discharge?	Yes	No
Number of pregnancies_____ Number of live Births _____		
Are you pregnant or breastfeeding?	Yes	No
Have you had a D&C, hysterectomy, or cesarean?	Yes	No
Any urinary tract, bladder, or kidney infections within the last year?	Yes	No
Any blood in your urine?	Yes	No
Any problems with control of urination?	Yes	No
Any hot flashes or sweating at night?	Yes	No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	Yes	No
Experienced any recent breast tenderness, lumps, or nipple discharge?	Yes	No
Date of last pap and rectal exam?		

Men Only		
Do you usually get up to urinate during the night?	Yes	No
If yes, number of time _____		
Do you feel pain or burning with urination?	Yes	No
Any blood in your urine?	Yes	No
Do you feel burning discharge from penis?	Yes	No
Has the force of your urination decreased?	Yes	No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	Yes	No
Do you have any problems emptying your bladder completely?	Yes	No
Any difficulty with erection or ejaculation?	Yes	No
Any testicle pain or swelling?	Yes	No
Date of last prostate and rectal exam: _____		

Other Problems		
Check if you have, or have had, any symptoms in the following areas.		
Skin	Chest/Heart	Recent changes:_____
Head/Neck	Back	Weight
Ears	Intestinal	Energy level
Nose	Bladder	Ability to sleep
Throat	Bowel	Other pain/discomfort:
Lungs	Circulation	_____

Golden Corner Family Practice

FINANCIAL POLICY

If you need to cancel an appointment please call our office 24-48 hours before your scheduled appointment time. **If you no show three appointments in a year without cancelling, you may be terminated from the practice.**

Your copay or deductible is due at the time of each visit. It is your responsibility to know your benefit coverage. Please verify that we are part of your policies network. It is also your responsibility to provide our front office staff with your current and accurate insurance information, including an up to date copy of your insurance card and any changes regarding your insurance, address or phone number.

Returned Checks- A $50 service charge will be applied to your account for any returned check.

Forms- There is a $20 charge for all forms **not** completed during an office visit.

No- Show Appointments There is a $25 charge for missing an appointment. There is a $50 charge for New Patient No Show. A charge will given for all appointments not cancelled at least 24 hours prior to appointment time. You will be financially responsible for this fee, as insurance plans do not cover these charges. You may notify our office of any cancellations by calling our office during normal office hours.

Copies of Medical Records: There is a charge for completion of medical records.

- .65 per page for the first 30 pages
- .50 per page for all other pages
- Clerical fee not to exceed $25
- Plus actual postage

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 864-638-5402 to make payment arrangements.

Please bring all insurance cards to each appointment along with your co-payments or deductible payment.

Patient Signature: _____**Date**:_____

Golden Corner Family Practice

CONTROLLED SUBSTANCE GUIDELINE AND AGREEMENT

Patient: _____ DOB: _____

Pharmacy and Location: _____
Phone Number: _____

Narcotics, pain medications, tranquilizers, barbiturates, and sleeping pills are very useful, but have a high potential for misuse. Local, state and federal governments therefore closely monitor these drugs in all forms. They are intended to relieve pain, improve function, and or the ability to work. Because my physician is prescribing such medication for me to help manage my pain I agree to the following conditions:

1. I am responsible for my controlled medications. If the prescription or medication is lost, stolen or misplaced, I understand it will not be replaced.
2. I will not under any circumstance accept controlled medication from any other physicians or an individual. Doing so is illegal and may danger my health. The only exception is if it is prescribed during a hospital admission.
3. Refills of medication will only be made during office hours Monday-Friday. Refills will not be made at night; weekends or holiday's .Refills will not be made if I run out Early and do not realize it until Friday at closing. I am responsible for taking the medication as prescribed and keeping up with the due dates. I will call at least 24 hours ahead if I need assistance with a refill of my controlled medication.
4. My doctor may need to refer me to a medication use specialist at any time while I am receiving controlled substances. I understand if I do not keep this appointment my medication may not be continued or refilled beyond a tapering dose.
5. I understand that while taking controlled substances it is my responsibility to comply with the law including driving of automobile vehicles.
6. I understand the medication is used to treat pain and provide better function and I agree to also maintain all other areas of my health by being compliant with all medications such as diabetes and hypertension. If I should be non compliant with my health I understand my controlled substances may not be refilled.
7. **I understand that I may be asked to perform a urine drug screen at any given time. If I should be found to be negative for my medications, or positive for other substances not prescribed by my physician I understand that I may be terminated from the practice.**
8. I will not use any illegal substances including marijuana, cocaine, etc.
9. I will not share, sell, or trade my medication with anyone.
10. I will agree to have and pay for a drug test if suspected misuse of my medication.
11. I will agree at any given time to comply with pill counts and inspection of my controlled medications substances.

I AGREE TO USE THE PHARMACY I LISTED ABOVE FOR FILLING MY CONTROLLED SUBSTANCES:

Patient Signature: _____**Date**: _____

Golden Corner Family Practice Representative: _____**Date**: _____

Golden Corner Family Practice

Please be advised:

It is never permissible, under any circumstances, to contact any of our medical providers or staff members regarding your medical needs via any social media platform. It is also not acceptable to obtain their personal phone numbers in any manner and use it without their permission. The staff member will not respond.

Across the board the proper means of medial communication is to call the office directly. Not only is it disrespectful of the providers/ staff member's time and position, it is not HIPAA compliant to discuss your medical needs outside of the medical office. Should you need assistance after hours, you should call the office and you will then be directed to the provider on call. Failure to comply with this request may result in your dismissal from the practice.

Thank you,

The Golden Corner Family Practice Staff

Patient Signature: _____Date: _____

Golden Corner Family Practice

Designation of Care Providers for Communication of Protected Health Information

Patient Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: ____

Phone Number: (H) _____ (C) _____

I hereby request that my protected health information be communicated with others directly involved in my care. This designation of care providers will be kept as a permanent part of my medical record and will be copied as required in order to allow communication of my protected health information. I understand that my health care providers will use judgment in determining the minimum amount of information that must be shared in order to care for me.

Designation: (Specify name, relationship and any telephone numbers that will be allowed information to be given) Example: Reminders of appointments, calling back after you have called and left a message.

Name	**Relationship**	**Phone Number**

Please list any person(s) that you **do not** want any information given to:

_____

_____

Patient Signature: _____ Date: _____

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Release of Information Authorization

Patient Name: _____ **Date of Birth**: _____

Last 4 Digits of SSN: _____ **Phone Number**: _____

Address: _____ **City**: _____ **State**: _____ **Zip**: _____

Release Records To: (Where do you want the information sent?)

Name of individual, healthcare provider/hospital/practice: _____

Phone number: _____ Fax number: _____

Obtain Records From: (Who has the information you want released?)Please list all.

Name of Organization/hospital or Medical Practice: _____

Phone number: _____ Fax number: _____

Name of Organization/hospital or Medical Practice: _____

Phone number: _____ Fax number: _____

Name of Organization/hospital or Medical Practice: _____

Phone number: _____ Fax number: _____

Purpose of Release:

☐ntinuing Care ☐atient Request ☐hool ☐ther: _____

Treatment Dates:

☐eatment dates from _____ to _____ (please be specific) **OR** ☐l Treatment Dates

Information to be released:

☐ysicians Notes ☐b Results ☐adiology Reports ☐ental Health Information

☐mplete medical record

I understand this information may include references 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 Medical Records department. This authorization will expire/end one year from this date or _____.

Print Name of Patient or Legal Guardian/Representative: _____

Relationship to Patient, if signed by Legal Guardian: _____

Signature of Patient or Legal Guardian/Representative: _____ Date: _____

Golden Corner Family Practice

The **Golden Corner Family Practice** Patient Portal provides an easy-to-use, secure, web-based method for patients to access portions of their medical records on-line. This is available from any computer (desktop, laptop or tablet) with Internet access. When you log into the **Golden Corner Family Practice**

Patient Portal, you will be able to view information, including your medical conditions, medications, vital signs, lab results, allergies, and insurance policies.

Register for the **Golden Corner Family Practice** Patient Portal

Use this form to request a **Golden Corner Family Practice** Patient Portal account. Please fill-out this form as completely as possible. Once the form has been completed, it can be faxed to our Medical Records Department at **864-638-6126** or emailed to **Golden Corner Family Practice** You may also deliver this form in person during your next visit to any of our clinic locations. If you need assistance filling out the form, please call **864-638-5402** and a representative will assist you.

Once you have been registered for the **Golden Corner Family Practice** Patient Portal, you will receive an email from **Golden Corner Family Practice** with instructions to complete your Patient Portal registration.

Patient Registration Form

By completing this form, you are authorizing *Golden Corner Family Practice* to set up a Patient Portal Account. ***Please complete using CAPITAL LETTERS with one character in each block.***

FIRST NAME:	
LAST NAME:	
DATE OF BIRTH:	/ /
Last 4 Digits of SSN	
EMAIL ADDRESS:	
ZIP (Postal) Code #	-
Signature:	
Today's Date	/ /

☐Yes, I would like to be enrolled in the Golden Corner Family Practice Patient Portal.

Please allow 3 business days for your request to be processed.
A Golden Corner Family Practice representative may contact you to verify your information.

Golden Corner Family Practice

Notice of Privacy Practices Acknowledgement

I understand that the above practice will be sharing my protected health information.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read, and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____ Date of Birth: _____

Relationship to Patient (Patient Representative): _____

Signature: _____ Date: _____

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Notice of Privacy Practices and Acknowledgment

Golden Corner Family Practice makes every effort to keep your health information private. Each time you visit our practice, a record is made. This health or medical record often includes your symptoms, exams, and test, diagnoses, treatment, and care plan. We need this record to give you the highest quality of care and to meet legal requirements.

This Notice of Privacy Practices applies to all health records produced at Golden Corner Family Practice, 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.

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 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 records 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 transferring to.
- 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 your. 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 that they may bill and collect payment for treatment and services they provided to you.
- We may share your health information with billing can 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 activates). These used and disclosures are needed to run the practice, support treatment and payment, and help patients receive high-quality care. Activities may include measuring quality, reviewing employee performance and training students.

People Involved in Your Care or Payment for Your Care

We may share your health information with 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, Golden Corner Family Practice respects your right to choose not to have your information shared. 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.

Special Uses and Disclosures of Your Health Record

Emergencies

We may use or release your health information during emergencies.

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
We may release information about you to local, state or federal public health agencies (such as 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 or the public or another person. Disclosures are made only to those people able to help prevent or reduce the threat.

Coroner, 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 practice
- 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.