Providence
HEALTH

The Providence Heart
1655 Bernardin Avenue
Suite 220
Columbia, SC 29204
803-409-7170 office
803-409-7175 fax

Welcome to Providence Heart:

Please find enclosed a new patient packet that you will need to complete.

In order for Providence Heart to request and receive your medical records please complete the ivory page titled *'Authorization to Disclose Protected Health Information'*. **This page needs to be completed and returned to Providence Heart prior to your next cardiology appointment.**

The remaining pages of your new patient packet need to be completed and brought to your next Providence Heart appointment.

If you have any questions about this packet or would like to confirm and schedule your next cardiology appointment please call **Providence Heart at 803-409-7170.**

Thank you and we look forward to seeing you at our new office,

The Providence Heart Team

www.providencephysicians-sc.com/locations/providence-heart

Authorization to Disclose Protected Health Information

Patient Name: _____ Date of Birth _____

Address: _____

Phone Number: _____ Medical Record Number: _____

I authorize Providence Hospitals to use or disclose and/or receive Protected Health Information for the following purposes:

_____Further Care _____Insurance _____Personal Records _____Workers' Comp _____Attorney

Other (Specify) _____

Please select delivery method: ___ E-Delivery (secure web link) ___ Fax ___U.S. Mail ___ CD ___Patient to pick up

Release Protected Health Information to:

Name: **Providence Heart** Phone#: 803.409.7170

Address: 1655 Bernardin Avenue, Suite 220, Columbia, SC 29204

Email: _____ Fax# 803.929.3253

Type of information requested:

___Problem List ___Laboratory Data ___History & Physical ___Entire Record ___Medication List

___EKG ___X-ray Reports ___Immunization Record ___Office Visit ___Procedure Record

___Other: _____

I UNDERSTAND THAT:

- Upon request, I can inspect or obtain a copy of the information I am authorizing to be released. A fee for the cost of processing this request may be charged in accordance with SC State Law.
- The Protected Health Information used or dislocated under this authorization may be subject to redisclosure by the receiver and no longer protected by the Standards of Privacy of Individually Identifiable Health Information
- I understand that treatment, payment, enrollment in a health plan or eligibility for benefits may not be conditions on whether I sign this authorization.
- I authorize the following information to be disclosed: Drug and/or alcohol abuse or treatment; Psychiatric treatment; HIV (AIDS) testing/treatment; sexually transmitted disease testing/treatment.
- I understand that I may revoke this authorization in writing except to the extent that Providence Physicians Group/Providence Health has previously used or disclosed the Protected Health Information in reliance on this authorization. To revoke this authorization, I understand that I must deliver a signed written statement clearly stating that I revoke this authorization to health Information management Services, Augustine Health Group/Providence Hospitals, 2435 Forest Drive, Columbia, SC 29201
- If I have any questions about the disclosure of my Protected Health Information I can contact the Privacy Office for Providence Physician Group/Providence Health at 800-565-0675

This authorization expires six months from the date of signature, or on: _____

_____ _____

Signature of Patient or Legal Representative/Guardian Date

Providence HEART

NEW PATIENT HISTORY & PHYSICAL

PATIENT NAME:	DATE:
REFERRING PHYSICIAN:	DOB:
REASON FOR VISIT:	
CURRENT MEDICATIONS:	
ALLERGIES:	

FAMILY MEDICAL HISTORY (INDICATE FAMILY MEMBER)

Asthma Yes ☐No☐	High Blood Pressure Yes ☐No☐	Cancer/Breast Cancer Yes ☐No☐	Thyroid Disease Yes ☐No☐
Kidney Disease Yes ☐No☐	Tuberculosis Yes ☐No☐	Seizures Yes ☐No☐	Diabetes Yes ☐No☐
Heart Disease Yes ☐No☐	Congestive Heart Failure Yes ☐No☐	COPD Yes ☐No☐	Peripheral Vascular Disease Yes ☐No☐

PAST MEDICAL HISTORY – DO YOU NOW OR HAVE YOU EVER HAD:

Asthma Yes ☐No☐	Heart Attack Yes ☐No☐	Hepatitis Yes ☐No☐	Stomach Disease /Peptic Ulcer Yes ☐No☐
Bleeding Disorder Yes ☐No☐	Pneumonia Yes ☐No☐	High Blood Pressure Yes ☐No☐	Tuberculosis Yes ☐No☐
Seizures Yes ☐No☐	Cancer/Breast Cancer Yes ☐No☐	Thyroid Disease Yes ☐No☐	Lung Disease Yes ☐No☐
Diabetes Yes ☐No☐	Kidney Disease Yes ☐No☐	Sleep Disorders Yes ☐No☐	Liver Disease Yes ☐No☐
Transfusion Yes ☐No☐	Coronary Artery Disease Yes ☐No☐	Congestive Heart Failure Yes ☐No☐	COPD Yes ☐No☐
Hospitalizations/Operations: Please list any hospitalizations or surgeries:			

PRESENT MEDICAL HISTORY – DO YOU CURRENTLY HAVE:

HEENT

Painful Sinuses Yes ☐No☐	Difficulty Swallowing Yes ☐No☐	Voice Changes or Hoarseness Yes ☐No☐	Goiter or Thyroid Enlargement Yes ☐No☐

CARDIOVASCULAR

Murmur or Abnormal Heart Sound Yes ☐No☐	Smothering Spells at Night Yes ☐No☐	Valvular Heart Disease Yes ☐No☐	Irregular Heart Beat or Palpitations Yes ☐No☐
Rheumatic Fever Yes ☐No☐	Blood Clots Yes ☐No☐	Heart Enlargement Yes ☐No☐	Chest Pain Yes ☐No☐
Coronary Artery Disease Yes ☐No☐	Sleep on More Than One Pillow Yes ☐No☐	Leg Pain, Limiting Exercise Yes ☐No☐	Swollen Legs Yes ☐No☐
Ankle Edema Yes ☐No☐	Excessive Sweating Yes ☐No☐	Dizziness Yes ☐No☐	Other

RESPIRATORY

Difficulty Breathing Through Nose Yes ☐No☐	Frequent Cough Yes ☐No☐	Coughing up Blood Yes ☐No☐	Chronic Nasal Discharge Yes ☐ No☐
Night Coughs Yes ☐No☐	Frequent Pneumonia Yes ☐No☐	Phlegm or Sputum Yes ☐No☐	Other
Unusual Shortness of Breath Yes ☐No☐	Wheeze Yes ☐No☐	Emphysema Yes ☐No☐	

G.I./G.U.

Acid Reflux Yes ☐No☐	Difficulty or Excessive Urinating Yes ☐No☐	Peptic Ulcer Yes ☐No☐	Black or Tarry Bowel Movements Yes ☐No☐
Hiatal Hernia Yes ☐No☐	Frequent Bladder Infections Yes ☐No☐	Abdominal Pain Yes ☐No☐	Kidney Stones Yes ☐No☐
Blood in Bowel Movement Yes ☐No☐	Nausea/Vomiting Yes ☐No☐	Constipation/Diarrhea Yes ☐No☐	Weight Gain/Loss Yes ☐No☐

NEURO

History of Stroke Yes ☐No☐	Memory Loss Yes ☐No☐	Difficulty Speaking Yes ☐No☐	Difficulty Sleeping Yes ☐No☐
Frequent or Severe Headaches Yes ☐No☐	Head Injuries Yes ☐No☐	Seizures Yes ☐No☐	Other

ENDROCRINE/REPRODUCTIVE

Hair Loss Yes ☐No☐	Poor Wound Healing Yes ☐No☐	Easy Bruising Yes ☐No☐	Dizziness When Standing Yes ☐No☐
High Cholesterol or Lipids Yes ☐No☐	High Blood Sugar Yes ☐No☐	Low Blood Sugar Yes ☐No☐	Abnormal Glucose Tolerant Test Yes ☐No☐

HEMATOLOGICAL

High White Blood Cell Count Yes ☐No☐	Low White Blood Cell Count Yes ☐ No ☐	Frequent Skin Infections Yes ☐No☐	Bleeding Gums Yes ☐ No ☐
Swollen Lymph Glands Yes ☐No☐	HIV or AIDS Yes ☐ No ☐	Anemia (low hemoglobin) Yes ☐No☐	Other Yes ☐ No ☐

VASCULAR (DO YOU NOW OR HAVE YOU EVER HAD)

Aching, cramping or pain in arms, legs or buttocks when walking or exercise Yes ☐ No ☐	Numbness or tingling in arms or lower legs and feet Yes ☐No ☐	Fingers or toes pale, discolored or bluish Yes ☐No☐	Hands or feet cold to the touch Yes ☐ No ☐
Sores or ulcers on legs or feet that will not heal Yes ☐ No ☐	Pain in toes or feet at night Yes ☐No ☐	Varicose Veins Yes ☐No☐	More than 25 pounds overweight Yes ☐ No ☐

SLEEP (DO YOU NOW OR HAVE YOU EVER HAD THE FOLLOWING)

Loud Snoring Yes ☐No ☐	Gasping Episodes at night Yes ☐No ☐	Overweight/Obese Yes ☐No ☐	Trouble Concentrating Yes ☐No ☐
Excessive Daytime Sleepiness Yes ☐No ☐	Awaken Unrested Yes ☐No ☐	Morning Headaches Yes ☐No ☐	Night Sweats Yes ☐No ☐
Nod off while driving Yes ☐No ☐	Loss of Energy/Fatigue Yes ☐No ☐	Dry Mouth/Sore throat Yes ☐No ☐	Nighttime Urinating Yes ☐No ☐
Legs restless or Jerks Yes ☐No ☐	Frequent Awakenings Yes ☐No ☐	Insomnia Yes ☐No ☐	Other

SOCIAL HISTORY (DO YOU NOW OR HAVE YOU EVER USED)

Smoked Cigarettes Yes ☐ No ☐ How long: Have You Quit Yes ☐ No ☐ If yes, when:	Chewed Tobacco Yes ☐ No ☐ How long: Have You Quit Yes ☐ No ☐ If yes, when:	Alcohol Yes ☐ No ☐ How long: Have You Quit Yes ☐ No ☐ If yes, when:	Other:
How Much Exercise Do You Get: Light ☐ Moderate ☐ Heavy ☐			
Occupation:			

Comments or Additional Information:

The information provided is true and accurate to the best of my knowledge.

Signature _____ Date _____

I have reviewed and discussed the questionnaire with the patient.

Physician's Signature _____ Date _____

WHEN COMPLETE, PLEASE HAND DIRECTLY TO PHYSICIAN

Today's Date ____/____/____

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Patient Name Last	First	Middle	☐ Mr ☐ Mrs ☐ Miss ☐ Ms	Marital Status (circle) Single/ Married / Divorced /Sep/ Widow
Is this your legal name? ☐ YES ☐ NO	If not, what is your legal name?		Birthdate / /	Age Sex ☐ M ☐ F ☐ T
Street or Mailing Address (circle one)	City	State	Zip Code	Home Phone Number ( )
Cell Phone Number ( )	E-Mail Address			Social Security - -
Occupation	Employer		Employer Phone Number	

Employment Status: ☐1 – Full-Time ☐2 – Part-Time ☐3 – Not Employed ☐4 – Self-Employed ☐5 – Retired ☐6 – Active Military
Student Status: ☐F – Full-Time Student ☐P – Part-Time Student ☐N – Not a Student

Race: ☐American Indian/Alaska Native ☐Asian ☐Native Hawaiian/Pacific Islander ☐Black/African American ☐White ☐Hispanic ☐Other ☐Declined

Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino ☐Declined

Language: ☐English ☐Spanish ☐Indian ☐Japanese ☐Chinese ☐Korean ☐French ☐German ☐Russian ☐Other _____

Pharmacy: Do you have a living will? ☐ YES ☐ NO

Referred By (Please check one box)
☐ Dr. _____ ☐ **Insurance** ☐ **Hospital** ☐ **Family** ☐ **Friend** ☐**Yellow Pages** ☐ **Other** _____

Other Family Members Seen Here

PCP Name Phone #

RESPONSIBLE PARTY INFORMATION

Responsible Party: ☐Another Patient ☐Guarantor ☐Self ☐Check here if information is same as patient

Name	Address	Home Phone Number ( )
Birth Date / /	E-Mail Address	
Occupation / Employer	Employer Address	Employer Phone Number ( )

INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Is this visit for one of the following? ☐ WORKERS COMPENSATION (WC)
☐ OCCUPATIONAL MEDICINE (OM) ☐ MOTOR VEHICLE ACCIDENT (MVA) ☐ ACCIDENT DATE _____

Does the patient have healthcare coverage? ☐ YES ☐ NO **Insurance Name**

Name of Insured	Social Security Number - -	Birth Date / /	Effective Date / /	Group ID	Subscriber ID (Policy Number)

Patient Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Name of Secondary Insurance	Name of Insured	Date of Birth / /	Group ID	Subscriber ID (Policy Number)

Patient Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other _____

EMERGENCY CONTACT

Name (Last, First)	Relationship to Patient	Home Phone Number ( )	Other Phone Number ( )

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge. I consent to receive text messages and/or email messages from the practice to any cell number and/or email provided which may include appointment reminders, bills, payment receipts, or marketing materials. I understand that a patient's care is directed by his/her physician(s) and I consent to any services that are appropriate for my care and as ordered by my physician(s).

_____ _____

Patient/ Guardian Signature Date

Providence Heart

FINANCIAL POLICY

Thank you for choosing us as your health care provider. The following is our Financial Policy. Our main concern is you receive the proper and optimal treatment needed to restore and maintain your health. Therefore, if you have any questions or concerns about our payment policies, please do not hesitate to ask our staff.

1. Your insurance will be filed as a courtesy to you; however you are responsible for the entire bill. **All co-payments, unmet deductibles and other patient responsible services must be paid at the time of the visit.** If your insurance carrier applies the billed charges to your deductible, denies the services, or considers the services non-covered, you are responsible for payment of the service. **If you do not have insurance, payment in full will be expected at the time of the visit.**

2. In the event your insurance company does not pay the claim within a reasonable amount of time (45 – 60 days) then you may become responsible for the bill. If payment is not received within a reasonable amount of time from the guarantor, or if we receive returned mail as undeliverable, we will place your account with an outside collection agency.

3. If your insurance plan requires a referral or prior authorization, you must present this along with your insurance ID at each visit. If you do not have the referral when you arrive for your appointment, payment for the visit becomes your responsibility.

4. Returned checks will be subject to a returned check fee. A fee may be charged for missed appointments.

5. **PATIENT'S CERTIFICATION, AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUESTS:** I certify the information given by me in applying for payment under Title XVIII of the Social Security Act (Medicare) is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I request that payment of assignment benefits be made on my behalf.

6. **FINANCIAL AGREEMENT:** The undersigned in consideration of the services to be rendered to the patient is obligated to pay the medical practice in accordance with its regular rates and terms, and if the account is referred to an attorney or agency for collections, to pay reasonable attorney's fees and collection expenses. The undersigned hereby assigns to the medical practice all insurance benefits for services provided. The undersigned agrees to be responsible for charges not covered by insurance. It is understood the obligation to pay the practice may not be deferred for any reason, including pending legal actions against other parties to recover medical costs.

7. **CONSENT FOR ROUTINE TREATMENT** I hereby consent to the performance of such diagnostic procedures and/or medical treatment as deemed necessary or advisable by my physician(s) at Providence Heart. I hereby consent to the performance of all nursing and technical procedures and tests as directed by my physician(s). I understand that my medical care may require the collection of samples, including fluids or tissues, from my body. This may include having blood drawn or tissues removed during tests, treatment, or surgery. Further, I understand that should any hospital or emergency medical personnel, physician, or other person(s) be exposed or report an exposure to my blood or body fluids, my blood will be tested for blood borne infections including Hepatitis Band C as well as HIV/AIDS. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatments or examination at Providence Heart. I have the right to refuse tests or treatment (as far as the law allows) and to be told what might happen if I do. I have the right not to have any photos or videos taken of me unless I agree to this, except as needed to treat me.

8. **ADVANCE DIRECTIVE:** ☐ I have executed an Advance Directive ☐ I have not executed an Advance Directive

I have read and fully understand the Financial Policy and have been given the opportunity to ask questions.

_____ _____

Signature of patient, legal representative for health care services Date

If other than patient:

_____ _____

Relationship of Representative Reason individual is unable to sign, i.e. minor or legally incompetent

NOTICE OF PRIVACY PRACTICES

EFFECTIVE DATE - April 14, 2003

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. PLEASE REVIEW THIS INFORMATION CAREFULLY. This notice applies to Providence Heart and the doctors and other healthcare providers practicing at this facility. This notice also applies to Providence Physician Group, LLC.

It is our legal duty and we are required by law to protect the privacy of your information and to notify you of certain breaches of your information. We are providing this notice so that we can explain our privacy practices. We will follow the practices described in this notice or the current notice in effect. We reserve the right to change our policies and notice of privacy practices at any time. If we should make a significant change in our policies, we will change this notice and post the new notice. You can also request a copy of our notice at any time. For more information about our privacy practices or to place a complaint or report a concern or conflict, call the number listed below:

Providence Hospitals Privacy Officer
1-800-565-0675

Or, if you prefer to remain anonymous, you may call the toll-free number listed next and an attendant will handle your concern anonymously. 1-877-508- LIFE (5433).

You may also send a written complaint to the United States Department of Health and Human Services if you feel we have not properly handled your complaint. You can use the contact listed above to provide you with the appropriate address or visit http://www.hhs.gov/ocr/privacy/. Under no circumstance will you be retaliated against for filing a complaint.

We may use health information about you for your treatment purposes, to obtain payment, or for healthcare operations and other administrative purposes. For example, we may use your information in treatment situations if we need to send your medical record information to a specialist or physician as part of a referral for continuing care. We will send your health information and other identifying information to Medicare, Medicaid or other health insurance plans for our billing purposes. Your information will be used when processing your medical records for completeness and to compare patient data as part of our efforts to continually improve our treatment methods. We may disclose your information to our business associates we contract with to provide service on our behalf that requires the use of our health information. We may contact you or disclose certain parts of your health information to our associate or related foundations, for fundraising purposes. You have the right to opt out of receiving such fundraising communications. We may share certain information with a person(s) you identify as a family member, relative, friend, or other person that is directly involved in your care or payment for your care, or if it becomes necessary to notify these individuals about your location, general condition, or death. In addition we may need to disclose medical information about you

to an entity assisting in a disaster relief efforts so that your family can be notified about your condition, status, and location.

Under certain circumstances we may be required to disclose your health information without your specific authorization. Examples of these disclosures are: requirements by state and Federal laws to report cases of abuse, neglect, or other reasons requiring law enforcement; for public health activities; to health oversight agencies; for judicial and administrative proceedings; for death and funeral arrangements; for organ donation; for special government functions including military and veteran requests, and to prevent serious threat to health or public safety. We may also contact you after your current visit for future appointment reminders or to provide you with information regarding treatment alternatives or other health related services that may be of benefit to you. Most uses and disclosures of psychotherapy notes, those for marketing purposes, and those that constitute a sale of medical information will only be made with your written authorization. We will obtain your written authorization for any other disclosures beyond the reasons listed above. Do remember, if you do authorize us to release your information, you always have the right to revoke that authorization later. We will be happy to honor that request except to the extent that we may have already acted.

As a patient, you have rights regarding how your information can be used and disclosed. These rights include access to your health information. In most cases, you have the right to look at or receive a copy of your health information. This may take up to 30 days to prepare and there may be a preparation fee associated with making any copies. You can ask for an accounting of disclosures. This is a list of instances in which we have disclosed your information for reasons other than treatment, payment and operations that you have not specifically authorized but that we are required to do by law (see section on how your information may be used and disclosed). We can provide you one list per year without charge; all additional requests in the same year will be subject to a nominal charge. If you believe that the information we have about you is incorrect or if important information is missing, you have the right to request that we amend or correct the existing information. There may be some reasons that we cannot honor your request for which you submit a statement of disagreement. You can also request that your health information be communicated to you at an alternate location or address that is different from the one we received when you were registered. If you pay for your service in full up front, you can ask that we not disclose information about your treatment to your health plan. Finally, you can request in writing that we not use or disclose your information for any reasons described in this notice except to persons involved in your care or when required by law, or in emergency circumstances. We are not legally required to accept such a request but we will try to honor any reasonable requests.

Providence Heart

HIPAA ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. The Notice contains a Patient Rights section describing your rights under law. You have the right to review our Notice before signing this acknowledgement. The terms of our Notice may change; if we change our notice you may request a revised copy by contacting our office or you will receive a new notice the next time you are treated at our office.

The practice provides this form to comply with the Health Information Portability and Accountability Act of 1996. (HIPAA)

The patient understands that:

- The practice has a Notice of Privacy Practices and that the patient has the opportunity to review this notice
- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The practice reserves the right to change the notice of privacy practices.

Please list names of individuals that we may *talk* to about your treatment. Please note this does not allow these individuals to obtain copies without a complete and valid authorization from the patient.

_____

_____

I acknowledge receipt of the Notice of Privacy Practices.

_____ _____

Printed Name of Patient or Representative Signature of Patient or Representative

_____

Date

Relationship to Patient (if other than patient) _____

☐ Check if patient refused to take a copy of the Notice of Privacy Practices

State reason for refusal, if known:

_____ _____

Witness (Staff) Signature Witness (Staff) Printed Name

_____

Date