Sports Medicine Institute Policies

Please arrive at least 30 minutes prior to your first visit, allowing adequate time for the check-in process. Our goal is for our physicians to see you as close to your appointment time as possible. **If you are more than 15 minutes late, we will reschedule your appointment.**

If the first new appointment to our office is "No-Showed", no additional appointments will be scheduled. For follow-up care visits, 3 No Shows or cancellations less than 48 hours before appointment time, within a 12 month period, could result in discharge from our practice:

- **1st occurrence will result in a reminder letter being sent**
- **2nd occurrence will result in a fee**
- **3rd occurrence will result in a discharge from the practice**

It is your responsibility to know your insurance benefits and requirements. If you have any questions concerning coverage of a certain test, visit type or procedure, please contact your insurance company prior to your visit. It is your responsibility to keep our office informed of any changes in your phone number, address, insurance information, and other pertinent information.

Patients under the age of 18 must be accompanied by a responsible adult or have written permission, for treatment, from a parent or guardian.

Bring either an up-to-date medication list *or* the medication bottles with you to each appointment. Remember to include medications prescribed by other physicians and any over the counter medications and supplements you are taking.

The best time to get a prescription refill is at your appointment. If you are requesting a new prescription please inform your physician during your scheduled appointment. New or refill requests made after your visit may result in a $10.00 fee. If you need to call in for a refill, please allow 24 hours for the physician to review your request and call the medication in. All refill requests must go through our refill request line. Please check with your pharmacy first to see if the prescription has been called in. Narcotic pain medications **will not** be called in.

We do not prescribe narcotics for chronic use. We do not call in narcotics after hours. If you require use of narcotics, our physicians will refer you to a pain management specialist. Narcotics that are prescribed through our office will require a signed Medication Use Agreement.

Samples are only available if we have them in stock; there is no guarantee that we will have the drug you may need. We do not stock pain medications!

There will be a $34.00 charge for completion of any forms, (i.e. disability forms, FMLA papers). Please allow 7 to 10 business days for completion of forms.

The Sports Medicine Institute has a no tolerance policy for rude, unkind or discourteous behavior toward the physician or office staff. In return, our staff is expected to extend kindness and respect to all patients.

Due to Emergency Call Coverage, we occasionally have to schedule patients on an emergency basis. We apologize for any delay you may experience at your appointment time.

If you need to request medical records, please be aware it may take 5 to 7 business days but we will make every effort to fulfill all request as quickly as possible. We are contacted with an outside vendor, Healthport, and upon the completion of records you may receive an additional bill.

Patient Signature_____Date:_____

Thank You For Choosing Spartanburg Regional For Your Healthcare Needs

Patient Registration Form

Please print or write legibly

Medical Group of the Carolinas

PATIENT INFORMATION

Name: _____ Date of Birth: _____ Sex: M F

Mailing Address: _____ Marital Status: S M LS D W

City: _____State_____ Zip_____ Social Security#: _____

Street Address (if different from mailing) _____ Email address: _____

City: _____State_____ Zip_____ Primary Language_____

Race: [ ] White/Caucasian [ ] Black/African American [ ] Native Hawaiian [ ] AM Indian/Alaska Nat [ ] Asian/E Indian [ ] Unavailable/Unknown

Ethnicity: [ ] Hispanic/Latino [ ] Not Hispanic/Latino [ ] Declined

Phone: Home: _____ Cell: _____ Work: _____ Preferred Phone: home cell work

Employer/School: _____Student: FT_____ PT_____ Primary Care Physician: _____

[If a minor] Childs Fathers Name _____Childs Mothers Name_____

[If the patient is a minor child] and the parents are legally separated or divorced please complete the following:

Which parent has legal custody of the minor child? _____

Which parent is financially responsible for the minor child's medical expenses after insurance? _____

Please provide a copy of the legal documentation stating the parent responsible for medical expenses to be included in the patient's medical record.

[ ] ***check if same as patient***

GUARANTOR INFORMATION (*person financially responsible for any patient balances*)

Name: _____ Date of Birth: _____ Sex: M F

Mailing Address: _____ Social Security#: _____

City: _____State_____ Zip_____ Relationship to Patient: _____

Phone: Home: _____ Cell: _____ Work: _____ Preferred Phone: home cell work

Employer/School: _____email address: _____

INSURANCE INFORMATION *(please provide copies of all medical insurance cards)*

Name of **Primary** Insurance: _____Certificate Number_____

Group Number _____Co Pay Amount _____Effective Date_____

SUBSCRIBER INFORMATION (*Person who carries the insurance*) **[ ] *Check here if same as the patient***

Name:_____DOB_____

Mailing Address: _____ Social Security#: _____

City: _____State_____ Zip_____ Relationship to Patient: _____

Phone: Home: _____ Cell: _____ Work: _____ Preferred Phone: home cell work

Employer/School: _____

Medical Group of the Carolinas

INSURANCE INFORMATION *(please provide copies of all medical insurance cards)*

Name of **Secondary** Insurance: _____Certificate Number_____

Group Number _____Co Pay Amount _____Effective Date_____

SUBSCRIBER INFORMATION (*Person who carries the insurance*) **[ ] *Check here if same as the patient***

Name:
_____DOB_____

Mailing Address: _____ Social Security#: _____

City: _____State_____ Zip_____ Relationship to Patient: _____

Phone: Home: _____ Cell: _____ Work: _____ Preferred Phone: home cell work

Employer/School: _____

Financial Policy

This information is to provide clarification for patients of Medical Group of the Carolinas regarding matters of insurance, co-pay, deductibles and co-insurance amounts due at the time of service. Physician Group Practices have an obligation to various Healthcare plans to apply any deductible and/or collect any co-payment prior to provision of services.

Co-Pays

You will be required to pay your co-payment upon arrival for your appointment

Deductibles and Co-Insurance

You will be asked at check in or check out for any deductible or co-insurance that may be applicable to your office visit

Previous Balances

You will be expected to provide payment for previous balances or balances sent to collections prior to your office visit. If you are unable to pay your balance in full, you may be asked to set up a payment plan. You may set up this plan with our office or contact Physicians Billing Service at 1-877-596-2455. Physicians billing service is Medical Group of the Carolinas billing service and will be glad to assist you with your questions about any billing inquiry

PLEASE SIGN THE ACKNOWLEDGMENT BELOW

I acknowledge that the above information is true and accurate demographic and insurance information for the patient listed on this registration form. I also acknowledge that by signing this form, I authorize payment of medical benefits to the undersigned physician or supplier for services described. I have also read the above Medical Group of the Carolinas financial policy and agree to the terms of the policy.

Patient Signature_____ Parent or Guardian Signature: _____

Medical Group of the Carolinas

Patient Name_____DOB:_____

PLEASE INDICATE YOUR PREFERRED METHOD OF CONTACT & HIPAA RELEASE OF INFORMATION

How would you like to be contacted regarding appointments, treatment and/or other information pertinent to your healthcare and/or payment for your healthcare provided at the Medical Group of the Carolinas.

[ ] Any Method of Contact

Restricted Contact Preferences

[ ] Home Telephone May we leave a message on your answering machine? [ ] Yes [ ] No

[ ] Cell Phone [ ] Work Phone [ ] Mail

HIPAA DELEGATES

[ ] OPTION 1: THESE ELECTIONS WILL BE IN EFFECT FOR ALL SRPG LOCATIONS

I authorize the person (s) listed below to receive all health information about appointments, treatment and/or other information pertinent to my healthcare and/or payment for my healthcare provided at the Medical Group of the Carolinas. These individuals will be designated as my *emergency contacts.*

Name:_____Relationship:_____Phone:_____

Name: _____Relationship:_____Phone:_____

HIPAA DELEGATES

[ ] OPTION 2: THESE ELECTIONS WILL BE IN EFFECT FOR ALL SRPG LOCATIONS

I do not authorize any information to be disclosed to any other parties except to me as the patient/guardian except in the event of an emergency. Please note the following are *emergency only contacts*

Name: _____Relationship:_____Phone:_____

Name: _____Relationship:_____Phone:_____

Minor Patient Release

[ ] MINOR PATIENT RELEASE OPTION 3: THESE ELECTIONS WILL BE IN EFFECT FOR ALL SRPG LOCATIONS

I authorize the following individual (s) to consent to medical treatment in my absence

Name: _____Relationship:_____Phone:_____

Name: _____Relationship:_____Phone:_____

PLEASE SIGN AND DATE BELOW

PATIENT/GUARDIAN SIGNATURE: _____**DATE**_____

Sports Medicine Institute

Today's Date_____ Patient Name:_____ Date of Birth:_____ Age:_____

Height:_____ Weight:_____ Referring Physician:_____ Date of Injury(s)_____

Sport/Activity you are trying to return to:_____ Hand Dominance: Right Left Both

Please circle your current pain level: 0 1 2 3 4 5 6 7 8 9 10
Mild Moderate Severe

Past Medical History NONE □

Have you had any medical problems?

High Blood Pressure	Yes / No
Heart Disease	Yes / No
Stroke	Yes / No
Emphysema	Yes / No
Diabetes	Yes / No
Kidney Disease	Yes / No
Thyroid Disease	Yes / No
Hepatitis	Yes / No
Immune Disease	Yes / No
Chemical Dependency	Yes / No
Arthritis	Yes / No
Blood Clots	Yes / No

Other: _____

Current Medications Please list all CURRENT medications: (If you have a list please give it to the Receptionist)

NONE □

_____
_____
_____
_____
_____
_____
_____
_____

Social History

Do You use:

Tobacco	Yes / No
Alcohol	Yes / No
Drugs	Yes / No
Exercise	Yes / No

Circle one: (Exercise)
Daily Weekly Monthly Never
Occupation:_____
_____
Unemployed:_____ Worker's Compensation:
Claim (this injury)? Yes / No On Disability? Yes / No

Past Surgical History Please list any surgeries you have had:
(If you have a list please give it to Receptionist)
NONE □

_____
_____
_____
_____
_____
_____

DRUG Allergies
List all ***DRUGS*** to which you are allergic to:
Please √ box if you have
□ **NO DRUG allergies**
□ **Allergic to Latex**

_____
_____
_____
_____
_____

Family History
Anyone in your family with:

Heart Disease:	Yes / No
Stroke:	Yes / No
Cancer:	Yes / No
Rheumatoid Arthritis:	Yes / No
Muscle Skeletal Disease:	Yes / No

Other:_____

Do you have:
Anyone to assist you at home: Yes/No
Steps into your home: Yes /No

***Review of Systems** Do you have any of these symptoms? **Please circle Yes or No for each condition**

Constitutional

Fever	Yes / No
Weight Loss/Gain	Yes / No

Heart

Chest Pain Irregular	Yes / No
Heart Beat Poor	Yes / No
Circulation	Yes / No

Genitourinary

Bloody Urine	Yes / No
Pain in Urinating	Yes / No
Unable to Urinate	Yes / No

Neurological

Paralysis	Yes / No
Frequent Headaches	Yes / No

Blood

Bleeding Problems	Yes / No
Blood Transfusion	Yes / No

GYN Date of last menstrual cycle: _____
Pregnant Yes / No

Eyes

Decreased Vision	Yes / No
Cataracts	Yes / No

Lungs

Shortness of Breath	Yes / No
Wheezing	Yes / No
Persistent Cough	Yes / No

Musculoskeletal

Joint Swelling	Yes / No
Muscle Aches	Yes / No
Joint Pain	Yes / No
Gout	Yes / No

Psychiatric

Depression	Yes / No
Bipolar	Yes / No

Allergies

Allergies to Food	Yes / No
Seasonal	Yes / No

Ear, Nose and Throat

Loss of Hearing	Yes / No
Sinus Problems	Yes / No

Gastrointestinal

Stomach Pain	Yes / No
Diarrhea	Yes/ No
Persistent Vomiting	Yes / No

Skin

Rash	Yes / No
Dryness of Skin	Yes / No

Endocrine

Thyroid Disease	Yes / No
Diabetes	Yes / No

Other: _____
_____ Are you being treated for these conditions?
Yes / No

Current Orthopedic Problem:

Foot	Elbow
Ankle	Forearm Wrist
Leg	Hand/Fingers
Knee	Shoulder
Hip	
Back	
Neck	

Right or Left

Fall: Twisting:	□
Car Accident:	□
Altercation:	□
Pulling:	□
Lifting:	□
Other:	□

_____

Symptoms: √ **those that apply**

Pain:	□
Popping:	□
Looseness:	□
Catching /Locking	□
Weakness:	□
Stiffness:	□
Numbness:	□ _____
Other:	

Physician:

Medical Group of the Carolinas

GENERAL CONSENT TO TREAT/
PATIENT AUTHORIZATION/ACKNOWLEDGEMENT OF BENEFITS RELEASE

The following are the conditions for services provided by the Medical Group of the Carolinas which is affiliated with Spartanburg Regional Health Services District, Inc. (District) for the patient whose name appears at the bottom of this page.

CONSENT FOR MEDICAL TREATMENT

I/we voluntarily consent to medical treatment and diagnostic procedures provided by Medical Group of the Carolinas and its associated physicians, clinicians and other personnel. I/we consent to the testing for infectious diseases, such as, but not limited to syphilis, AIDS, hepatitis and testing for drugs if deemed advisable by my physician. I/we am/are aware that the practice of medicine and surgery is not an exact science and I/we acknowledge that no guarantees have been made as to the result of treatments or examinations.

AUTHORIZATION FOR RELEASE OF INFORMATION

The practice and physicians are authorized to release any medical information required in the processing of applications or submission of information for financial coverage, discharge planning and further medical treatment. To include information referring to psychiatric care, sexual assault or tests for infectious diseases including AIDS/HIV for services provided during this visit. I/we also agree to the release of medical or other information about me to government federal or state regulatory agencies as required by law.

ASSIGNMENT OF INSURANCE BENEFITS

I/we guarantee payment of all charges made for or on account of the patient and I/we assign our rights in any insurance benefits or other funding to the physician and the Medical Group of the Carolinas. I/we understand that I/we am/are responsible for any charges not covered by insurance or other forms of benefits. I/we understand the Medical Group of the Carolinas can obtain my/our credit report for review in collection of this debt. In the event that this account is placed with a collection agency or attorney for collection or collected following the SC Setoff Debt Collection Act, I/we shall pay all collections fees and costs, including reasonable attorney's fees. For Medicare beneficiaries: I/we have provided all necessary information for proper assignment of Medicare benefits.

WORKER'S COMPENSATION PATIENT RECORDS RELEASE AND AUTHORIZATION FORM

I understand that South Carolina and North Carolina Worker's Compensation law provides that written information which pertains directly to a workers' compensation claim must be provided by a healthcare facility/physician to the insurance carrier, the employer, the employee, their attorneys, or the applicable State Workers' Compensation Commission pursuant to the SC Code Ann § 42-15-95 and NC ST § 97-27. **I authorize Medical Group of the Carolinas to provide copies of my medical records or to speak to duly authorized representatives of any of the above regarding my medical records, medical treatment, or condition.**

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I/we have received a copy of the Notice of Privacy Practices. The notice describes how my health information may be used or disclosed. I understand that I should read it carefully. I am aware that the Notice may be changed at any time. The Notice of Privacy Practices may be accessed at www.srhs.com.

_____	_____
Date and Time	Signature of Patient/(Relationship to Patient) (Parent, Guardian or Legally Authorized Representative)
_____	_____
Hospital Witness	Signature of Guarantor (Relationship to Patient)