Thank You For Choosing Spartanburg Regional Healthcare System For Your Healthcare Needs

Medical Group of the Carolinas
A Division of Spartanburg Regional Healthcare System

Patient Registration Form

REGIONAL OCCUPATIONAL HEALTH

Please print or write legibly

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
May Choose Multiple Races [ ] Declined to provide

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

Phone: Home: _____ Cell: _____ Work: _____

EMPLOYMENT INFORMATION

Employer: _____ Employer Telephone Number_____

Employer Address: _____

Date of Accident/Injury: _____ Nature of Accident or injury: _____

Contact Person/Supervisor: _____

Temporary Agency

Agency Name: _____ Telephone Contact Number_____

Contact/Supervisor: _____

Reason for Visit Today

_____

_____

_____

_____

_____

_____

_____

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EMERGENCY CONTACTS

THE PERSON OR PERSONS BELOW WILL BE CONTACTED IN THE EVENT OF AN EMERGENCY

Emergency Contact 1 _____ _____ _____
First Name Last Name Telephone

Emergency Contact 2_____ _____ _____
First Name Last Name Telephone

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 with the exception of approved and authorized payment responsibility from your employer and/or workers compensation carrier

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 with the exception of approved and authorized payment responsibility from your employer and/or workers compensation carrier

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: _____

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PLEASE INDICATE YOUR PREFERRED METHOD OF CONTACT INFORMATION

Patient Name_____DOB:_____

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?

[ ] I may be contacted by "Any Method" If not "any method" please choose Restricted Contact Preferences

Restricted Contact Preferences [ ] Home Telephone [ ] Cell Phone [ ] Work Phone [ ] Mail [ ] E-Mail

May we leave a message on your answering machine/voicemail? [ ] Yes [ ] No

Of the selected preference or preferences above what is your preferred method of contact or how would you like to be contacted first?

[ ] Home Telephone [ ] Cell Phone [ ] Work Phone [ ] Mail [ ] E-Mail

HIPAA INFORMATION

HIPAA DELEGATES

[ ] OPTION 1: THESE ELECTIONS WILL BE IN EFFECT FOR ALL MGC 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.

Name:_____Relationship:_____Phone:_____

Name: _____Relationship:_____Phone:_____

HIPAA DELEGATES

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

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