



**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.

TELEPHONE AUTHORIZATIONS

You hereby grant permission and consent to us, our assignees, and third party collection agents: (1) to contact you by telephone at any telephone number associated with you, including wireless numbers: (2) to leave answering machine and voicemail messages for you, and include any such messages information required by law (including debt collection laws) and/or regarding amounts owed by you: (3) to send you text messages or emails using any email addresses you provide: (4) to use pre-recorded/artificial voice messages and/or an automatic dialing device (an "auto dialer") in connection with any communications made to you or related to your account.

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 Spartanburg Regional Healthcare System (SRHS) 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.srlhs.com.

Date

Signature of Patient/(Relationship to Patient)
(Parent, Guardian or Legally Authorized Representative)

Hospital Witness

Signature of Guarantor (Relationship to Patient)

Patient Name: _____

Yes	No	List allergies you have:
		Allergies (specify):
Yes	No	List medications you take:
		Medications (specify):
		1.
		2.
Yes	No	Do you have any of the following?
		Cancer (specify type):
		Asthma
		Heart Disease (CAD)
		Stroke (CVA)
		Depression / anxiety
		Diabetes
		Diverticulitis
		Hyperlipidemia
		Hypertension
		Hypothyroidism
		Peptic ulcer
		Other:
Yes	No	Have you had Surgeries or Operations?
		Surgeries (specify):

Yes	No	Does your family have any of the following?
		Blood Diseases: <input type="checkbox"/> Father <input type="checkbox"/> Mother
		Cancer or Leukemia: <input type="checkbox"/> Father <input type="checkbox"/> Mother
		Diabetes: <input type="checkbox"/> Father <input type="checkbox"/> Mother
		Heart Disease: <input type="checkbox"/> Father <input type="checkbox"/> Mother
		High Blood Pressure: <input type="checkbox"/> Father <input type="checkbox"/> Mother
		Strokes: <input type="checkbox"/> Father <input type="checkbox"/> Mother
		Mental Illnesses: <input type="checkbox"/> Father <input type="checkbox"/> Mother
Yes	No	Do you use alcohol, drugs or smoke?
		Tobacco Use: How much ? _____ Week.
		Alcohol Use: How much ? _____ Week.
		Drug Use: Describe use & drug: _____
Yes	No	Are you employed?
		How long Employed?
		Position?
Yes	No	Menstrual History (woman):
		Are you pregnant?
		Last menstrual date?
		Last pap smear date?
		Left or right handed? <input type="checkbox"/> Left <input type="checkbox"/> Right
		Last Tetanus shot date?

Yes		No		Are you experiencing any of the following conditions/symptoms TODAY?
				CONSTITUTIONAL
				Change in appetite
				Chills
				Fatigue
				Fever
				Sweats
				Weight loss
				EYES AND VISION
				Blurred or double vision
				Contact lenses
				Eye discharge
				Eye pain
				EARS, NOSE, THROAT, TEETH
				Dizziness
				Ear pain
				Nasal congestion
				Nose discharge
				Sneezing
				Sore throat
				CARDIOVASCULAR / HEART
				Chest pain or pressure
				Fainting
				Irregular heart beat
				RESPIRATORY / LUNGS
				Congestion
				Cough
				Shortness of breath
				Wheezing
				GASTROINTESTINAL SYSTEM
				Abdominal pain
				Diarrhea
				Nausea
				Urinary / Bowel changes
				Vomiting
				GENITOURINARY
				Discharge
				Frequent urination
				Nighttime urination
				Painful urination
				MUSCULOSKELETAL
				Joint pain
				Muscle pain
				Swelling
				SKIN
				Easy bruising
				Rash / Itching
				Redness
				Skin sores
				NEUROLOGICAL
				Headache
				Light headedness
				Numbness
				Poor balance
				Tingling
				Weakness
				PSYCHIATRIC
				Anxiety/Nerves
				Depression
				ENDOCRINE SYSTEM
				Diabetes
				Hyper or hypothyroid
				Heat or cold intolerance
				HEMATOLOGIC/BLOOD DISORDERS
				Frequent infections
				Swollen glands
				IMMUNE SYSTEM
				Hay fever or allergies
				Food allergies

Room _____ PO % _____ Resp _____ Pulse _____ BP _____ Temp _____ Weight _____ Height _____ Patient Vitals: Chief Complaint _____

Signature: _____

Date: _____

Spartanburg County Employee
Health Clinic
Medical History forms

Date: _____

Why are you here today?

What are here for today? (Chief Complaint): _____

Date of Illness / Injury: _____ Time of Illness / Injury: _____

Patient Information:

Last Name: _____ First Name: _____ Social Security: _____ - _____ - _____

Street Address: _____ Birth Date: _____ Age: _____

City, State, Zip: _____ Home Phone: _____

Other Address: _____ Work Phone: _____

Sex: Male Female Marital Status: Single Married DL #: _____

Person to contact in case of Emergency: _____ Phone: _____

Patient Employer or Guarantor:

Employer Name: _____ Department: _____

Street Address: _____ Employer Phone: _____

City, State, Zip: _____ Supervisors Name: _____

Other Address: _____

Occupation: _____

Insurance Information:

Is the insurance carrier responsible for your visit, your private insurance or your employer's workers compensation insurance? _____

Private Insurance Employee's Workers Comp Insurance Name of Insurance: _____

Assignment of Benefits - Financial Agreement:

I hereby authorize _____ examine and treat my condition as the doctor(s) deem appropriate and I have authority for those procedures to be performed. I clearly understand and agree that all services rendered are charge directly to me and that I am responsible for payment of services by this office and all outside laboratory or radiology services performed on my behalf. Should collection of past due amount become necessary, I will become responsible for all charges, fees and attorney fees. I (we) hereby authorize the doctor/provider to release all information necessary to secure payments of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Patient / Guardian: _____ Date: _____

Consent to Treat a Minor: YOU MUST HAVE DOCUMENTATION OF GUARDIANSHIP AND/OR CUSTODY FOR WORK WHEN BRINGING IN A MINOR

I (we) being the parents, guardian or custodian of the minor being:

Last _____ MI _____ First _____ Age _____ do hereby authorize, request, and direct Work Fit, the doctors and staff to perform examinations, diagnostic, X-ray, laboratory tests, and any treatment that in their judgment is deemed advisable or is required while said minor child is under care of this office's doctors and staff until legal age. All charges for service and care given to said minor child will be charged directly to me (us) and I (we) will be personally responsible for payment of them. I (we) hereby authorize the doctor/provider to release all information necessary to secure payments of benefits. I authorized the use of this signature on all insurance submissions.

Parent, Guardian, or Custodian Signature: _____ Date _____

Relationship to Patient: _____ Witness _____ Date _____