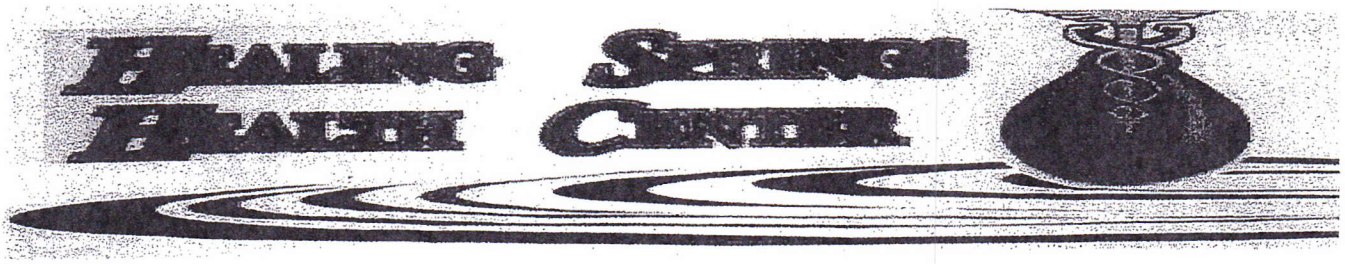
EFFECTIVE January 1, 2019

ALL MISSED VISITS WITHOUT A 24 HOUR NOTICE WILL BE CHARGED $25.00

Signature _____



What is the reason for your visit today? _____ _____

Patient Information

Name (First, Middle, Last)	**Birth Date**	**Age**	**Social Security #**	**Sex:** ☐ **M** ☐ **F**

Address	Apt. #	City	State	Zip

Email Address (We will never rent or sell your email address – we value your privacy.)

Home Phone	Cell Phone
Okay to leave voice message? ☐ Yes ☐ No	Okay to leave voice message? ☐ Yes ☐ No

Employer (or Parent's Occupation if minor)	Work Phone

Responsible Party or Parent's Name (if minor)	Guarantor Birth Date	Guarantor Social Security #

Preferred Language	**RACE** ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White
ETHNICITY ☐ Hispanic or Latino ☐ Not Hispanic or Latino	

Emergency Contact

Name	Relationship	Home Phone	Cell Phone

Address	City	State	Zip	Email Address

Preferred Pharmacy

Pharmacy Name	Pharmacy Location

Insurance | Please present your insurance card to the receptionist.

PRIMARY INSURANCE CARRIER			**SECONDARY INSURANCE CARRIER**		
Insurance Company Name			Insurance Company Name		
Address			Address		
City	State	Zip	City	State	Zip
Phone	Policy Number		Phone	Policy Number	
Group Number / Name			Group Number / Name		
Insured Name & DOB			Insured Name & DOB		
Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Dependent			Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Dependent		

Patient Medical History

Today's Date: _____

Patient Name: _____ Date of Birth: _____

Allergies

☐ No Known Allergies

Medicine _____ Other _____

Current Medications (include non-prescription products)

☐ No Current Medications

1. _____ 3. _____ 5. _____ 7. _____

2. _____ 4. _____ 6. _____ 8. _____

Preferred Pharmacy Pharmacy Name: _____ Location: _____

Patient History

PLEASE MAKE AN (X) BY ANY OF THESE CONDITIONS YOU MAY HAVE HAD IN THE PAST:

- ☐ Heart disease
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Lung disease
- ☐ Diabetes
- ☐ Hypoglycemia (low glucose)
- ☐ Thyroid disease
- ☐ Stomach disease
- ☐ Kidney, bladder or prostate disease
- ☐ Joint replacement
- ☐ Liver disease
- ☐ Bowel disease
- ☐ Cancer (past or present)
- ☐ Anemia or other blood disease
- ☐ Blood clots
- ☐ Bleeding tendency
- ☐ Stroke
- ☐ Seizures
- ☐ Nerve impairment
- ☐ Cervical spine disorder
- ☐ Lumbar spine disorder
- ☐ Severe headaches
- ☐ Tuberculosis/TB
- ☐ Muscle disease
- ☐ Mental health problems
- ☐ Depression
- ☐ Chronic skin disease
- ☐ Sleep apnea
- ☐ Other: _____

PAST MEDICAL CONDITIONS:

Approximate Date Condition _____ Approximate Date Condition _____

Approximate Date Condition _____ Approximate Date Condition _____

ORTHOPEDIC OR OTHER MAJOR SURGERIES:

Approximate Date Surgery _____ Approximate Date Surgery _____

Approximate Date Surgery _____ Approximate Date Surgery _____

Family History

Mother:	☐ Hypertension	☐ Diabetes	☐ Cancer	☐ Other (please specify) _____	☐ N/A
Father:	☐ Hypertension	☐ Diabetes	☐ Cancer	☐ Other (please specify) _____	☐ N/A
Brother:	☐ Hypertension	☐ Diabetes	☐ Cancer	☐ Other (please specify) _____	☐ N/A
Sister:	☐ Hypertension	☐ Diabetes	☐ Cancer	☐ Other (please specify) _____	☐ N/A
Grandmother (M):	☐ Hypertension	☐ Diabetes	☐ Cancer	☐ Other (please specify) _____	☐ N/A
Grandmother (P):	☐ Hypertension	☐ Diabetes	☐ Cancer	☐ Other (please specify) _____	☐ N/A
Grandfather (M):	☐ Hypertension	☐ Diabetes	☐ Cancer	☐ Other (please specify) _____	☐ N/A
Grandfather (P):	☐ Hypertension	☐ Diabetes	☐ Cancer	☐ Other (please specify) _____	☐ N/A

Personal Habits

Do you drink alcoholic beverages? ..... ☐ Yes ☐ No If yes, _____ drinks per ☐ Day ☐ Week ☐ Month

Do you smoke or chew tobacco? ..... ☐ Yes ☐ No If yes, _____ per day, _____ years of use

Do you use an e-cigarette? ..... ☐ Yes ☐ No If yes, _____ per day, _____ years of use

Review of Symptoms

	Do you have		If yes, explain
SKIN	Rashes, bumps, lumps, open sores, or wounds	☐ Yes ☐ No	
HEAD | EYES | EARS NOSE | THROAT	Failing eyesight, falls, seizures, vertigo, blackouts, hoarseness, or nasal congestion	☐ Yes ☐ No	
LUNGS	Unexpected breathlessness, wheezing (day or night), blood in sputum, or chronic cough	☐ Yes ☐ No	
HEART	Chest pain, irregular heartbeat, or pacemaker	☐ Yes ☐ No	
BOWELS	Blood in stool, change in bowel habits, worrisome indigestion, or abdominal pain	☐ Yes ☐ No	
BLADDER | KIDNEY	Trouble urinating, infections, or blood in urine	☐ Yes ☐ No	
EMOTIONAL	Any mental health problems, depression, or suicidal tendency	☐ Yes ☐ No	
MUSCULOSKELETAL	Arthritis, fractures, injuries, muscle weakness, or cramping	☐ Yes ☐ No	

Workers' Compensation

Not Applicable ☐

IS THIS A WORKERS' COMPENSATION CLAIM? ☐ Yes ☐ No

Workers' Compensation Billing Address

I hereby authorize HSHC to speak to a rehabilitation specialist, my employer, my insurance carrier or other professionals involved in my care of rehabilitation, regarding my medical records and the treatment I have received or will receive.

X _____ _____

Patient or Authorized Person's Signature Date

Accident/Injury Information (if applicable)

Not Applicable ☐

Where did the injury occur? (example: park) _____

Were you struck by an object? ☐ Yes ☐ No If Yes, what type of object? _____

Where did you fall? (example: kitchen, bathroom, garage) _____

Where did you fall from? (example: ladder, roof, steps) _____

If you were in a motor vehicle accident, were you the driver or passenger? _____

Authorization for Release of Information

Can we leave results to internal and external office testing or referrals in email or voicemail? ☐ Yes ☐ No

Whom can receive information on your behalf regarding testing or referrals? Name: _____

Patient Consent for Treatment

1. I voluntarily consent to any and all health care treatment and diagnostic procedures provided by HSHC and its associated physicians, clinicians and other personnel. I am aware that the practice of medicine and other health care professions is not an exact science and I further state that I understand that no guarantee has been or can be made as to the results of the treatments or examinations at HSHC.
2. I consent to the use and disclosure of my/the patient's protected health information for purposes of obtaining payment for services rendered to me/the patient, treatment and health care operations consistent with the HSHC Notice of Privacy Practices.
3. I authorize payment of medical benefits to HSHC physicians or their designee for services rendered.
4. I give permission to obtain all my medication/prescription history when using an electronic system to process prescriptions for my medical treatment.

I have received a copy of the Notice of Privacy Practice and Financial Policy Notice. ☐ Yes ☐ No Initial ____

X _____ _____

Patient or Authorized Person's Signature Date

FOR INTERNAL USE ONLY

DocuTAP Visit ID: _____ Co-Pay Collected: $ _____

MEDICAL RECORDS RELEASE FORM

To:
Physician Name: _____ Pt Name: _____DOB_____

Fax #:_____ Pt. MCA Acct #:_____

Portions of Record Needed----Check Applicable Sections

- ☐ Discharge Summary
- ☐ History & Physical
- ☐ Operative Rpt
- ☐ ER Record
- ☐ Stress Test Rpt
- ☐ Chest X-Ray
- ☐ Echo Report
- ☐ EKG/Stress Strips
- ☐ Holter/Event Monitor
- ☐ Lab Work
- ☐ Physician's Progress Notes
- ☐ Physician's Orders
- ☐ Other:_____

FAX REQUESTED RECORDS TO:

Healing Springs Health Center
P. O. Box 97
128 Medical Sciences Drive
Union, SC 29379
(p) 864-441-0723
(F) 864-441-0725

Treatment Dates requested: _____

Information about you is protected under federal law and you have the right to revoke this Authorization except to the extent that we have taken action in reliance on your Authorization. Please contact the MCA Medical Records Department for an "Authorization Revocation" form if one is needed. By signing below, you recognize that the protected health information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and may no longer be protected under federal law.

Expiration: Unless otherwise, revoked, this authorization will expire on the following date, event, or condition: If I do not specify an expiration date, event, or condition, this authorization will not expire. Date: ___/___/____

Patient's Signature:_____ Date: ___/___/____
As a Personal Representative, I have authority to act for the individual because I am :_____

PATIENT AUTHORIZATION FOR STUDENT OBSERVATION AND PARTICIPATION

HEALING SPRINGS HEALTH CENTER participates in clinical education programs with area colleges and universities. Healing Springs Health Center pariticpates to give students engaged in a course of study related to a medical career; including nursing students, interns, medical students, and residents experience in clinical practice. Your physician or nurse practitioner has agreed to permit such students to observe and participate in his/her patient care activities, including, where appropriate, providing medical care to patient under the physician's direct supervision.

By signing below, you agree to permit the students working in this physician's office to observe and participate in your medical care during your appointment today, including, where appropriate, providing direct medical care to you under your physician's direct supervision. You agree that you have been given the opportunity to refuse to give such consent and that you may withdraw your consent at any time during your appointment.

Patient Name (printed)_____

Patient Signature _____Date_____ Time_____

Witness Signature _____Date_____

IF THE PATIENT IS UNABLE TO CONSENT OR IS A MINOR COMPLETE THE FOLLOWING:

This patient, whose name is written above, is a minor, 18 years of age or is otherwise unable to consent to and execute this document for the following reason:

Describe reason: _____

_____

I hereby execute this document on the patient's behalf. I have read and fully understand each part of this document. I represent and verify that I am authorized to execute this document on behalf of the patient named above. I understand that I am entitled to receive a signed copy of this document.

_____ _____

Signature of parent of minor patient, custodial parent, guardian, or legal representative

Relationship to patient

Date_____ Time_____

Witness Signature_____

HEALING SPRINGS HEALTH CENTER PATIENT RESPONSIBILITLY AGREEMENT FOR CONTROLLED SUBSTANCE PRESCRIPTIONS

Controlled substances medications (i.e. narcotics, tranquilizers, benzodiazepines, and barbiturates) are very useful for controlling both acute and chronic pain but have a high potential for misuse and are, therefore, closely controlled by local state, and federal governments. They are intended to relieve pain, thus improving quality of life, function and/or ability to work. Because my physician is prescribing controlled substance medications to help manage my pain and or improve my ability to work, and or quality of life, I agree to the following conditions.

TREATMENT GOALS

I understand that the main treatment goal is to reduce the pain to a bearable level and improve the quality of my life. If I am prescribed medications for behavior or attention disorder, they are to improve my ability to be a functional member of my family and or the workforce. I understand that the medications may not eliminate the symptom for which they are prescribed. In consideration of this goal, and because I am being given a potent medication to help me reach my goal, I agree to help myself by following better health habits. The health habits include increase in activity and exercise, weight control, and avoidance of tobacco and alcohol. I understand that medications prescribed to me to initiate weight loss are short term prescriptions. I must comply with the treatment plan as prescribed by my physician. I understand that a successful outcome to my treatment will only be achieved by following a healthy lifestyle.

PATIENT'S RESPONSIBILITLY

- I am responsible for the controlled substance medications prescribed to me. If my prescription is lost, misplaced, or stolen, or if I "run out early", I understand that **the prescription will not be replaced.**
- I give permission for my physician to discuss all my diagnostic and treatment details with other physicians providing my medical care and with my pharmacists for purposes of maintaining accountability. This includes a copy of this contract.
- I will use **only one pharmacy** for all my prescription refills. I will register the name and phone number of this pharmacy with my physician.
- I know that telephone refills are not allowed. Calls or faxes from pharmacies to refill medications will not be authorized.
- **I agree to bring the bottles of all the medications prescribed by my physicians to each visit. Medications will be counted and the number of refilled checked.**
- I understand that driving a motor vehicle or operating machinery may not be allowed while taking controlled substance medications. It is my responsibility to comply with the laws of the State of South Carolina while taking the prescribed medications.

- At any time while I am receiving controlled substance medications, it may be deemed necessary by my doctor that I see a medication-use specialist. I understand that if I do not attend such an appointment, my medications will be discontinued or may not be refilled beyond a tapering dose to completion. I understand that if the specialist feels that I am at risk for psychological dependence (addiction); my medications may be tapered to completion.
- I will comply with random **PILL COUNTS**. These will be performed during regular office hours. The purpose of the **PILL COUNT** is to monitor medication usage. The number of pills missing from the bottle must correlate to the number of says since the prescription has been filled. A discrepancy in the number of pills missing is to be considered a breach of this contract and thus grounds for termination. Patients who fail to show for random pill counts will be immediately terminated from the practice. The pill counts will be randomly scheduled by the clinical staff.
- I agree to undergo random urine and or blood drug testing at the discretion of my doctor. The test will show the presence of my prescribed medication but will also show any illicit drugs. If a urine specimen cannot be produced at the time requested a blood drug screen will be drawn, processed, and billed to the patient. The presence of illicit drugs of the absence of my prescribed medications will be considered a breach of this contract and therefore grounds for dismissal from the practice. Failure to comply with the test will be considered grounds for dismissal from the practice. Prescriptions will not be released to the patient until specimen results are validated. There is no exception to this policy for Friday afternoon or dates prior to holidays.
- **I will not request or accept controlled substance medications from any other physician or individual while I am receiving controlled medications form Healing Springs Health Center. I will not give, share, or sell my medications to any other person.**
- **I understand that I must maintain Healing Springs Health Center as the site of my primary care physician while being prescribed controlled medication.**
- **Leaving the facility prior to providing the requested urine or blood specimen or refusing a pill count results in my termination of this contract and as a patient of Healing Springs Health Center.**

MEDICATION REFILLS

Will be made only during regular office hours Monday through Friday, in person. This will be done during a scheduled office visit as instructed by the physician. Refills will not be made after hours, on weekends, or holidays. There are no exceptions.

Will not be made if I, "run out early", or "lose a prescription", "spill, misplace or report them stolen". I am responsible for taking the medication in the dose prescribed and for keeping track of the amount remaining. I am also responsible for keeping the medications in a secure location as to avoid their theft.

Will not be made as an emergency such as on a Friday afternoon because I suddenly realize that I will run out tomorrow. I will call at least 24 hours in advance to schedule an appointment for refills.

RISK OF CHROINC OPIOD USE

I understand that the long-term advantages and disadvantages of chronic opioid use have yet to be scientifically determined. My treatment may change at any time. I understand, accept, and agree that there may be unknown risks associated with the long-term use of controlled substances, and that my physician will advise me of any advances in this field making treatment changes as deemed appropriate.

I am aware that tolerance to analgesia means that I may require more medicine to get the same amount of pain relief. If this occurs, increasing doses may not always help and may cause unacceptable side effects. Tolerance or failure to respond to opioids may force my doctor to choose another form of treatment.

(Female patient only) I am aware that if I plan to become pregnant or believe that I have become pregnant while taking these medications, I will immediately call my obstetric doctor to inform them. I am aware that there could be some adverse effects on my baby.

I have been fully informed by Healing Springs Health Center staff regarding the potential for psychological dependence (addiction)j to controlled substance medications. I know that some individuals develop a tolerance to their medications requiring a dose increase to achieve the desired effect. There is a risk of becoming physically dependent on the medication. This can occur if I am on the medication even for a short period of time. Therefore, when I need to stop taking the medications, I must do so under medical supervision. I am aware that I may have withdrawal symptoms. I may be advised to participate in a formal out-patient/in-patient program to be tapered off the medications. Healing Springs Health Center is not responsible for withdrawal syndrome if the medications are used inappropriately.

TERMINATION OF CARE

I understand that if I violate any of the above conditions, my treatment with controlled substance medications will be **terminated immediately**, without a 30-day notice. If the violation involves obtaining controlled substance medications from another person, or selling them to another individual, or the concomitant use of non-prescription illicit (illegal) drugs, the situation will be reported to all my physicians, medical facilities, and appropriated legal authorities. **I am responsible** for any withdrawal syndrome that may occur due to my misuse of the narcotic medication and/or termination of my care.

I have read this contract and the same has been explained to me by Healing Springs Health Center. Any questions have been answered to my satisfaction. I agree to comply fully with this contract. In addition, I fully accept the consequences of violating this contract.

Patient Signature_____Date_____

Witness Signature_____Date_____

Copy given to patient_____ Patient refused copy_____

Patient violated contract. Date_____

Healing Springs Health Center Staff Signature_____

Notary Stamp/ Signature if indicated.