LRMC | LITTLE RIVER MEDICAL CENTER

PATIENT DEMOGRAPHICS

Last: _____ Suffix ◯ II ◯ III ◯ IV ◯ Jr ◯ Sr

First: _____ Middle Initial _____

Previous Name: _____ What name would you like us to use? _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell/Mobile Phone: _____ Work Phone: _____

Email: _____

Date of Birth (mo/day/yr): _____ / _____ / _____ Social Sec #: _____ - _____ - _____

Sex at Birth: ◯ Male ◯ Female

Gender Identity (18 and older): ◯ Male ◯ Female ◯ Transgender Male-to-Female ◯ Transgender Female-to-Male ◯ Genderqueer ◯ Additional Gender ◯ Choose not to disclose

Sexual Orientation (18 and older): ◯ Straight or heterosexual ◯ Lesbian/Gay ◯ Bisexual ◯ Choose not to disclose ◯ Other_____

Preferred Pronouns (18 and older): ◯ he/him/his/his/himself ◯ she/her/her/hers/herself ◯ they/them/their/theirs/themselves ◯ Another Pronoun (please specify): _____

Marital Status: ◯ Single ◯ Married ◯ Legally Separated ◯ Divorced ◯ Widowed ◯ Life Partner

Primary Language : ◯ English ◯ Spanish ◯ Portuguese ◯ American Sign Language (ASL) ◯ Other _____

Race : ◯ African American/Black ◯ American Indian/Alaska Native ◯ Asian Indian/Asian ◯ Chinese ◯ Filipino ◯ Japanese ◯ Korean ◯ Guamanian or Chamorro ◯ Native Hawaiian ◯ Other Asian ◯ Other Pacific Islander ◯ Samoan ◯ Vietnamese ◯ White

Ethnicity : ◯ Not Hispanic/Latino ◯ Hispanic/Latino ◯ Mexican ◯ Mexican American ◯ Chicano/a ◯ Puerto Rican ◯ Cuban

Student Status: ◯ Full-time student ◯ Part-time student ◯ Not a student

Employment Status: ◯ Full-time ◯ Part-time ◯ Self-employed ◯ Retired ◯ Unemployed

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Responsible Party Name *(person financially responsible for any patient balances):* _____

Relationship to patient: _____ Responsible Party Date of Birth (mo/day/yr): ____/____ / _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Responsible Party Phone: _____

Emergency Contact: _____ Phone Number: _____ Relationship: _____

◯ I am interested in learning more or applying for your sliding fee discount program.

Family income data is needed by the government for us to get federal funding and see if you qualify for our sliding fee discount program. Your personal information is not shared with anyone. We do provide the information collectively as an organization. We appreciate your assistance. Please select the range that best suits your family's income.

In Family _____

◯ $0 - $10,000 ◯ $10,001 - $20,000 ◯ $20,001 - $30,000

◯ $30,001 - $40,000 ◯ $40,001 - $50,000 ◯ $50,001 - $60,000

◯ $60,001 - $70,000 ◯ $70,001 - $80,000 ◯ $80,001 or greater

◯ Choose not to disclose.

Residential Address (if mailing address is a PO BOX)

Street Address: _____ City: _____ State: _____ Zip: _____

DEMOGRAPHIC INFORMATION

(This information is for demographic purposes only.)

Military Status : ◯ Veteran ◯ Not a Veteran

Do you rent or own your home/apartment? ◯ Yes ◯ No If no, are you staying: ◯ In a Shelter ◯ with Friends/Family

◯ Permanent Supportive Housing ◯ Transitional Housing ◯ Street ◯ Other: _____

Have you or your family established a temporary home to work in agriculture? ◯ Yes ◯ No

In the past 2 years, have you or a member of your family worked in agriculture on a seasonal basis? ◯ Yes ◯ No

Voter Registration: ◯ Already Registered ◯ Would like to register ◯ Not interested in registering

How did you hear about Little River Medical Center? ◯ Billboard ◯ Newspaper ◯ Family/Friend ◯ Radio

◯ Hospital ◯ Other Physician Practice ◯ Television ◯ Phone Book ◯ Online/Website ◯ Social Media

◯ Community Event ◯ Other _____

Would you like to use Little River Medical Center as your primary pharmacy? ◯ Yes ◯ No

Preferred Pharmacy Name: _____

Pharmacy Address: _____

Pharmacy Phone Number: _____

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Patient Name: _____ Date of Birth: _____ Account Number: _____

CURRENT MEDICATIONS

_____
_____
_____
_____
_____
_____
_____
_____

SURGICAL HISTORY

Yes	No	
		Tonsils
		Appendix
		Gall Bladder
		Hernia
		Breast
		Hysterectomy
		Tubal Ligation
		Caesarean Section
		D & C
		Heart

Other:

_____
_____
_____
_____

FAMILY HISTORY

(Do any family Members have any of these problems)

Yes	No	
		Coronary Artery Disease
		Hight Blood Pressure
		Cardiovascular Disease
		Diabetes
		Breast Cancer
		Colon Cancer
		Prostate Cancer
		Asthma
		Hyperlipidemia

Other:

_____
_____
_____
_____

PAST MEDICAL HISTORY

(Have you had or presently have any of the following problems)

Yes	No	
		Artificial Joint
		Diabetes
		Tuberculosis
		Cancer/Chemotherapy
		Epilepsy (seizure)
		Rheumatic Fever
		German Measles
		Hepatitis (Jaundice)
		Phlebitis (blood clot)
		Nervous Problem
		High Blood Pressure
		Low Blood Pressure
		Anemia-Blood Disease
		Blood transfusion
		Asthma/Hay Fever
		Cholesterol
		Freq. Vaginal Infection
		Venereal Disease
		HIV/Aids
		Peptic Ulcer/Stomach
		Gout
		Heart Surgery
		Heart Disease
		Heart Murmur
		Mitral Valve Prolapse
		Osteoporosis
		Congenital Heart Disorder
		Heart Attack
		Heart Pacemaker
		Irregular Heartbeat
		Angina/Chest Pain Disorder
		Arthritis
		Stroke
		Excessive Bleeding
		Sickle Cell Disease
		Liver Disease
		Hepatitis A, B, C

Other:

_____
_____
_____
_____
_____

SOCIAL HISTORY

◯ Single ◯ Married
◯ Separated ◯ Divorced
Do you smoke: ◯ Yes ◯ No
How many years: _____
How many per day: _____
Do you drink alcohol: ◯ Yes ◯ No
How many per week: _____
Do you drink coffee: ◯ Yes ◯ No
Cups per day: _____
Do you wear a seatbelt: ◯ Yes ◯ No

ALLERGIES

◯ No known allergies
◯ Penicillin
◯ Sulfa
◯ Local Anesthetics
◯ Egg/Egg Products

Other: _____
_____
_____
_____

FEMALES ONLY

Last delivery date: _____
Regular Menses: ◯ Yes ◯ No
Irregular Menses: ◯ Yes ◯ No
Last Menstrual Period: _____
# of pregnancies: _____
# of living children: _____
Birth control method: _____

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Authorization for Release of Medical Information

I authorize LRMC to release any medical information pertinent to payment of medical expenses incurred by me to the insurance carriers names below or its intermediaries, carriers, agents, or billing agents. I permit a copy of the authorization to be used in place of the original request for payment of medical insurance benefits either to myself or to the party who accepts assignments.

Insurance Carrier	Date	Policy Number
Insurance Carrier	Date	Policy Number

Cardholder's Name: _____ SSN: _____ Relationship to Patient: _____

Cardholder's DOB: _____ Phone Number: _____ Cell Phone: _____

ASSIGNMENT OF INSURANCE BENEFITS

I hereby assign by rights under the above-named policy of insurance to Little River Medical Center including but not limited to major medical and dental insurance, hospital benefits, sick benefits, or injured benefits. In the event a third party is deemed liable for any medical conditions, I assign my rights under an insured such as auto insurance workman's compensation insurance and/or minimum medical hospital or disability payments commonly referred to as "PIP" pursuant to Section 56-11*110 S.C. Code of Laws, 1976, as amended, and the proceeded of all claims resulting from the liability of the third party payable by any person, employer, insurance company to or for me up to the full amounts of the medical/dental charges incurred. In addition, I further warrant and represent that any insurance assigned is valid insurance and in effect.

PERSONAL LIABILITY

I expressly understand that I am personally responsible for the entire amounts of medical/dental/behavioral health expenses incurred by me for care and treatment, either inpatient or outpatient. Any payment received by Little River Medical Center as a result of the above Authorization for Release of Medical Information and Assignments of Insurance Benefits will be credit towards y accounts, and I will be personally liable for all remaining balance on any Little River Medical Center's Medical, Behavioral Health or Dental Accounts.

INSURANCE OR HOUSEHOLD INCOME INFORMATION UPDATE

I will always inform the office of Little River Medical Center of all insurance changes and household income changes or updates. Failure to do so may result in (me) _____ paying for services rendered in full.

CONSENT FOR MEDICAL/DENTAL/BEHAVIORAL/PHARMACY CARE AND TREATMENT

I authorize Little River Medical Center to render medical/dental care and treatment as they deem appropriate under the directions of my primary care physician/dentist and of such associates, partners or designees as may be selected to perform such treatment. I recognize during the course of treatment, conditions may arise that necessitate additional procedures or services, and I further authorize and request that my physician/dentist and/or associates, partners, assistants, or designees as may be selected by him to perform such procedures, services are in their best professional judgement.

For the purpose of advancing medical knowledge, I consent to the admittance of medical students, translators, and observers in accordance with ordinary partners of this medical facility ◯ **Yes** ◯ **No** I authorize pharmaceutical manufactures and their auditors to access my pharmacy records as a part of my participation in their patient assistance program, if I participate in such program. I understand that this information may include medication and protected health information. (_____) initials.

I, _____, give consent to disclose **(a)** ◯ **all my personal healthcare information (PHI) or (b)** ◯ **only the following PHI** _____

During my visit to Little River Medical Center (LRMC) to the following individuals and these individuals may pick up my medication from LRMC Pharmacy and receive PHI results by telephone from LRMC:

Name	Relationship	Phone Number	Cell Phone Number

I, _____, Legal Guardian of Minor Child, _____, give permission for LRMC to disclose PHI about the above Minor Child during **(a)** ◯ **healthcare visit, and/or (b)** ◯ **on the telephone to the following individuals, who may also pick up the minor child's medication from the LRMC Pharmacy:**

Name	Relationship	Phone Number	Cell Phone Number

This authorization shall be in force and effective until: _____ at which time this authorization to disclose this information expires. No guarantees or assurances have been made or given by anyone as to the results that may be obtained by any treatment or procedures rendered to me. By signing below, the undersigned certifies that the foregoing paragraphs have been read in full and understood by the undersigned and all information is true.

Signature of Patient/Guardian: _____ Date: _____

Witness: _____ Date: _____

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Little River Medical Center Payment Policy

For us to continue to serve you and your family's health care needs, we ask that you abide by our payment policy.

- Payment is due and payable at the time service is rendered. Any other arrangements must be made with the business office manager, or designee, prior to being seen.
- Little River Medical Center reserves the right to control appointments until financial arrangements have been made.
- Little River Medical Center will file insurance claims with only certain insurance carriers. The front office will discuss your policy with you at the time of your first visit. Depending upon your insurance company, a co-payment and/or percentage may be required at check in.
- Little River Medical Center is not responsible for follow-up with insurance carriers. When payment from the insurance carrier has not been received within 45 days of filing, the responsible party will then receive a statement that payment will be expected within 15 days.
- Patients qualifying for our sliding fee program are responsible for payment in full for services or rates that have been set on a sliding scale.
- Payment is expected at the time of service. Accepted forms of payment include cash, check, Master Card, and VISA.

The undersigned hereby acknowledges to have read and agrees with the above payment policy of Little River Medical Center.

Signature of Patient/Guardian Date

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Acknowledgement of Privacy Practices

We are committed to protecting your personal health information in compliance with the law. The attached Notice of Privacy Practices states:

- Our obligations under the law with respect to your personal health information.
- How we may use and disclose the health information that we keep about you.
- Your rights relating to your personal health information.
- Our rights to change our Notice of Privacy Practices.
- How to file a complaint if you believe your privacy rights have been violated.
- The conditions that apply to uses and disclosures not described in this Notice.
- The person to contact for further information about our privacy practices.

We are required by law to give you a copy of this Notice and to obtain our written acknowledgement that you have received a copy of this Notice.

Patient Acknowledgement of Receipt

I, _____, hereby acknowledge that I have received a copy of the Notice of Privacy Practices.

Patient Signature Date

Patient Representative Signature (if applicable) Date

Description of Legal Authority to Act on Behalf of the Patient

Interoffice Use Only

In lieu of patient signature, I, _____, a staff member of Little River Medical Center, stated that _____ has been given our current Notice of Privacy Practices.

Date: _____

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Patient Rights and Responsibilities

Little River Medical Center has adopted the following Patient Rights and Responsibilities. The health and well-being of patients is dependent on a collaborative effort between patients and their providers in an open and respectful manner. Patients are expected to understand their rights and assume certain responsibilities.

Patient's Rights:

You have the right to:

Treatment

- Receive treatment without discrimination as to race, color, religion, sex, national origin, disability, sexual orientation, or source of payment.
- Receive complete information about your diagnosis, care plan, and prognosis.
- Receive emergency care if you need it.
- Participate in all decisions about your treatment and care plan.
- Refuse treatment or refuse to take part in research.
- Receive continuity of care by your provider coordinating your care with other health care professionals when necessary.
- Change providers if other qualified providers are available and select a pharmacy of your choice.

Privacy and Confidentiality

- Privacy while in the medical center and confidentiality of all information and records regarding your care.
- Review your health records without charge and obtain a copy of your health record for which the medical center can charge a reasonable fee. You cannot be denied a copy solely because you cannot afford to pay.

Mutual respect and conduct

- Receive considerate and respectful care in a clean and safe environment.

Communication and Satisfaction

- Receive all the information that you need to give informed consent for any proposed procedure or treatment. This information shall include the possible risks and benefits of the procedure or treatment.
- Seek assistance, such as a wheelchair or interpreter, which makes obtaining care easier.
- Express any complaints or concerns to LRMC's Administration by calling 843-663-8306.

Patient's Responsibilities:

Please assume the following responsibilities:

Patient History

- Provide accurate and complete information about present complaints, past illnesses, hospitalizations, medications, allergies, and other matters relating to your health.
- Report unexpected changes in your condition to the provider or other professionals who are responsible for your care.

Understanding your care

- Honestly indicate whether you clearly understand your care plan and what your role is in the plan.
- Follow the care plan recommended by your health care team.
- If you do not understand or agree with your care plan, discuss with your provider or other health care professional responsible for your care.
- Keep your appointments or call to cancel or reschedule your appointment.

Mutual respect and conduct

- Follow rules and regulations of the medical center regarding patient care and conduct (Examples: No smoking, No weapons, etc.).
- Be considerate of the rights of other patients and medical center personnel.
- Be respectful and use appropriate language and behavior with medical center personnel, other patients, and visitors.

Financial obligations

- Ensure that the financial obligations for your care are promptly fulfilled, regardless of the type of insurance or other health care coverage you have.
- Notify LRMC if you are concerned about financial difficulties with fees and payments so that other payment arrangements and/or financial assistance programs can be explored.

Patient Signature/Patient Representative Signature Date