

Patient Information:

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 Code: _____

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

Preferred Appointment Reminders: Phone Call Text Message Preferred Time to Call: Morning Afternoon Evening

Email: _____

Date of Birth (mm/dd/yyyy): _____ / _____ / _____ Social Security #: _____ - _____ - _____

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 Rica Cuban

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

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

Responsible Party Information:

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

Relationship to Patient: _____ Responsible Party Date of Birth (mm/dd/yyyy): _____ / _____ / _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____ Responsible Party Phone: _____

Emergency Contact Information:

Name: _____ Phone Number: _____

Relationship to Patient: _____

Residential Address (if mailing address is a PO BOX):

Street Address: _____

City: _____ State: _____ Zip Code: _____

Additional Patient Information:

As a community health center, Little River Medical Center offers a sliding fee discount program to all patients. This benefit can help lower the cost of healthcare services provided by Little River Medical Center and make medications more affordable at our Little River Medical Center pharmacy locations. Any patient, with or without insurance, can apply and qualification is based on income and household size. Please complete the information below:

In Family: _____

\$0 - \$10,000

\$30,001 - \$40,000

\$60,001 - \$70,000

\$10,001 - \$20,000

\$40,001 - \$50,000

\$70,001 - \$80,000

Choose not to disclose

\$20,001 - \$30,000

\$50,001 - \$60,000

\$80,001 or greater

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

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: _____

In the past 2 years, have you or your family established a temporary home to work in agriculture? Yes No

In the past 2 years, have you or a family member worked in agriculture on a seasonal basis (ex: picking fruit)? 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
 Social media Community Event Other: _____

Pharmacy Information:

After your appointment your prescription(s) will be sent to our LRMC Pharmacy. Which location would you like to use:

Select Preferred Location: Little River Carolina Forest Loris South Strand

I would like to use another local or mail order pharmacy for my medications (specify below)

Pharmacy Name: _____

Pharmacy Address: _____

Current Medications & Allergies:

List all current medications you are taking:

Medication Name	Dosage	How often do you take it? (ex. Once a day)

List any allergies you have:

Name	Reaction

No Known Allergies

Surgical History, Past Medical History, & Social History:

Have you had any past surgeries (Check all that apply):
 Appendix Breast Caesarean Section D&C
 Gall Bladder Gender Reassignment Surgery Heart Hernia Hysterectomy Tonsils
 Tubal Ligation Other: _____

Do you have or have you had any of the following (Check all that apply):
 Anemia-Blood Disease Angina/Chest Pain
 Arthritis Artificial Joint Asthma/Hay Fever Blood Transfusion Cancer/Chemotherapy
 Cholesterol Congenital Heart Disorder Diabetes Epilepsy (seizure) Excessive Bleeding
 Frequent Vaginal Infections Gout Heart Attack Heart Disease Heart Murmur
 Heart Pacemaker Hepatitis A, B, C Hepatitis (Jaundice) High Blood Pressure HIV/AIDS
 Irregular Heartbeat Liver Disease Low Blood Pressure Mitral Valve Prolapse Nervous Problem
 Osteoporosis Peptic Ulcer/Stomach Phlebitis (Blood Clot) Rheumatic Fever
 Sickle Cell Disease Stroke Tuberculosis Venereal Disease Other: _____

Marital Status: Single Married Widowed Divorced

Do you Smoke: Yes, current smoker How many years: _____ How many per day: _____
 Former Smoker When did you quit? _____ No, I have never smoked

Do you drink alcohol: Yes No If Yes, how many per week: _____

Do you drink coffee: Yes No If Yes, how many cups per day: _____

Do you wear a seatbelt: Yes No

Have you ever been screened for colorectal Cancer? Yes If Yes, When: _____ No

Female History:

Last delivery date: _____ Regular Menses: Yes No Last Menstrual Period: _____
 # of Pregnancies: _____ # of Living Children: _____ Birth Control Method: _____
 Last Pap Smear: _____ Last Mammogram: _____

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: _____

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

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/Patient Representative Signature

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: _____

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