SPARTANBURG & PELHAM OB-GYN, P.A.

Patient Information **Account #** _____

Name _____ Date of Birth _____
Address _____
City _____ State _____ Zip Code _____
Home Phone _____ Cell Phone _____
Social Security Number _____ Drivers License _____
e-mail _____ Marital Status _____
Religion _____ Primary Language _____

Race: ___ African American/Black ___ Asian ___ Native Hawaiian/ Pacific Islander ___ Declined
___ American Indian/ Alaskan Native ___ Caucasian/White ___ Other Race ___ Unknown

Ethnicity: ___ Declined ___ Hispanic or Latino ___ Not Hispanic or Latino ___ Unknown

Employer/School _____ Occupation _____

Emergency Contact Name / Relationship _____
Emergency Contact Number: _____ Cell: _____

Primary Care Physician _____ Referring Physician _____
Preferred Pharmacy _____ Location _____

Name of Insurance: (list in order of relevance)
Primary Insurance Co: _____ Policy # _____
Name of Insured _____ Date of Birth _____
Secondary Insurance Co: _____ Policy # _____
Name of Insured _____ Date of Birth _____
Tertiary Insurance Co: _____ Policy # _____
Name of Insured _____ Date of Birth _____

Responsible Party's Name _____ Date of Birth _____
Responsible Party's Phone _____ Employer _____
Responsible Party's Social Security Number _____

If you are 18 or a student, please complete the following:
Can we contact your parents regarding insurance information? ___ Yes ___ No
Are you covered under your parent's Insurance? ___ Yes ___ No

I hereby authorize and consent to all examination and treatment necessary for the care of the patient named below. I consent to any and all procedures incident to such treatment which are deemed necessary by the physicians. I authorize the release of medical information to process my claims and authorize Spartanburg & Pelham OB-GYN, P.A. direct receipt of insurance payment for services rendered. I hereby agree to pay Spartanburg & Pelham, OB-GYN, P.A. for all charges not covered by my insurance. I further acknowledge that I have been provided with a copy and given the opportunity to review the Notice of Privacy Practices of Spartanburg & Pelham OB-GYN, P.A. pursuant to the Federal regulations known as HIPPA privacy.

_____ _____
Signature of Patient or Responsible Party Date

_____ _____
Printed Name Relationship to Patient

SPARTANBURG & PELHAM OB-GYN, P.A.

Patient Information **Account #** _____

Contact Information

Patient 's Name _____ Date of Birth _____

I would prefer communications from the office to be:
___ Phone ___Cell ___Home ___Email ___ Patient Portal ___ Letter

Patient Portal

We are excited to invite you to join our patient portal. The portal will allow you to communicate with your provider, view upcoming appointments and view your health information including, but not limited to lab results. Please ask the staff at check-in to send you an invite via email to activate your account.
https://myhealthrecord.com Register Email: _____

Access to Your Medical Record

Please list all persons whom we may release or discuss your medical information with. Your spouse does not automatically have access to all of your health information, so please include spouse on the list, if you want them to have access to your health information.

Name: _____ Relationship: _____ Phone: _____
Name: _____ Relationship: _____ Phone: _____
Name: _____ Relationship: _____ Phone: _____

Telephone/ Text/ Email Messages

The staff and physicians of Spartanburg & Pelham OB-GYN, P.A., have my permission to leave all necessary messages regarding the patient listed above on voicemail, answering machine, text, or by email through a secure site. **This would only authorize us to remind you of an appointment, scheduled surgery or discuss billing matters. No detailed medical information will be given.**

Release of Medical Information

I authorize Spartanburg & Pelham OB-GYN, P.A. to release all medical records to the referring physicians and any other physician(s) who may be involved in my health care treatment, if applicable. I agree to allow my medical records to be sent by mail, fax, secure email or secure internet.

Medicare Patients Only

I authorize Spartanburg & Pelham OB-GYN, P.A. to receive direct receipt of insurance payment(s) for services rendered by the physician. I authorize my medical records to be released to The Health Care Financing Administration and its agents, whom require further determination of these benefits or befits payable for the related services, by mail, fax or secure email. _____ (initial)

_____ _____
Signature of Patient or Responsible Party Date

_____ _____
Printed Name Relationship to Patient

SPARTANBURG & PELHAM OB-GYN, P.A.

Patient Name: _____

Account #: _____

Office Financial and Payment Policy

Thank you for choosing Spartanburg OB-GYN, P.A. as your healthcare provider. We are committed to providing you and your family with the best possible medical care. In our ongoing process to make sure all of your medical needs are met, we would like to present our Office Financial and Payment Policy in order to minimize misunderstanding about fees. We ask that all responsible parties read and sign this policy prior to seeing the physician. This policy is offered in an attempt to develop and sustain a continued professional and pleasant relationship. Our billing department will be available to discuss our fees and this policy with you.

As a courtesy to you, Spartanburg OB-GYN, P.A. will bill your insurance carrier for services provided. In order to properly bill your insurance company, we require that you disclose all insurance information including primary and secondary insurance, as well as any changes of insurance information. Failure to provide complete insurance information may result in patient responsibility for the entire bill. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. Any laboratory tests which require an outside lab to perform will be billed separately by that company.

As the responsible party, please understand (initial each of the following):

____ 1. Payments for all services, which include unpaid balances, deductibles, co-payments, or other non-covered services as set by your insurance carrier are due at the time services are rendered. In order to service you better, we accept cash, check, Visa, MasterCard, Discover and Care Credit.

____ 2. Returned checks will be subject to a fee of $35.00.

____ 3. If you participate in a high-deductible health plan, we require that you pay 50% of unmet deductible or 80% of billable charges, which is lesser of the two, at the time of service. If we receive notification from your carrier that our claim did not process to your deductible we will refund any monies owed to.

____ 4. Self Pay Patients will be expected to pay at the time of service. If you are not able to pay in full, you must contact our billing department prior to being seen by the physician to make payment arrangements.

____ 5. We are participating providers with Medicare and will bill Medicare for all covered services. If you have a supplemental insurance, we will bill your supplemental insurance. If you do not have a supplemental insurance, your portion, which is 20% of the amount allowed by Medicare and Medicare deductible, will be collected at the time of each service. You will be expected to pay the allowed amount until you have met your Medicare deductible each year.

____ 6. I understand that if I fail to make any of the payments for which I am responsible in a timely manner and my account becomes delinquent, I agree to be responsible for any and all cost of collecting monies owed. This is including, but not limited to, court costs, litigation costs, and attorney's fees of 30% associated with any necessary collection procedures brought about by Spartanburg & Pelham OB-GYN, P.A., should that be necessary. We reserve the right to turn any account that becomes delinquent over to a collection agency or attorney's office who would then manage the collection of your account.

____ 7. When an appointment is scheduled with a physician, time is specifically allocated for you. We understand there may be times you are unable to keep an appointment, but we ask the courtesy of a phone call to cancel your appointment. We require 24 hour notification of cancellation, failure to do so will result in a $25 no-show fee. Failure to show 3 times will prevent us from rescheduling any appointments for you.

At Spartanburg & Pelham OB-GYN, P.A., we understand that financial problems may affect timely payment, so we encourage you to communicate any such problems to us so that we may assist you in keeping your account in good standing. If you have any questions, please contact our billing department at (864) 208-2321.

I understand the above information and will be responsible for the patient listed above.

_____ _____

Signature of Patient or Responsible Party | Date

_____ _____

Printed Name | Relationship to Patient

Name: **Date of Birth:** **Date:**

Reason for visit:

Surgical History: **Please list all surgeries with dates:**

Medication: Are you currently taking any medication(s)? ____Yes ____No

List all medications you are currently taking, including over-the-counter medications, vitamins, and herbal remedies:

Reason for taking current medication(s):

List any allergies to medications: ___No Known Allergies

LATEX Allergy: ___Yes ___No

GYN History:

Date of last period began: _____ How many days does your period last: _____

How often do you have a period: _____

Are you sexually active: ___Yes ___No New Partner: ___ Yes ___No

Sexual Preference: ___Male ___Female ___Both Number of lifetime partners: _____

Method of Birth Control:

___Condom ___ Implanon ___Partner with Vasectomy

___ Pills ___ Vaginal Ring ___ Natural Family Planning

___ Patch ___ Tubal Ligation ___ Other _____

___ IUD ___Depo Provera ___None

Social History:

Do you smoke? ___Yes ___No If "yes" how many packs per day _____ Age you started smoking ____

Do you drink alcoholic beverages? ___Never ___Occasionally ___Frequently

Do you drink caffeinated beverages? ___Never ___Occasionally ___Frequently

Do you use illicit drugs ___Never ___Occasionally ___Frequently If "yes" what type of drug:

Do you exercise? ___Never ___Occasionally ___Frequently _____

Obstetrical History: Please include all pregnancies

Total # Of Pregnancies _____

Delivery Date	Weight of Child(ren)		Delivery Outcome
_____	_____Vaginal	_____ C-section	_____
_____	_____Vaginal	_____ C-section	_____
_____	_____Vaginal	_____ C-section	_____
_____	_____Vaginal	_____ C-section	_____
_____	_____Vaginal	_____ C-section	_____

Total # of miscarriages: _____ Year(s) and weeks' gestation: _____

Full Term pregnancies: _____ D&C: _____ Elective abortion(s): ___Yes ___No

Pre-Term pregnancies: _____ Year(s) and weeks' gestation: _____