PATIENT INFORMATION

Last Name	First Name	M.I.	Social Security #
Address			
Home Telephone	Cell Phone	Date of Birth	Age
Email:	Yes! Sign me up for Genesis email updates.	Consent to Call Yes No Consent to Text Yes No	

Please Check All That Apply

Gender: Male Female

Insured's Language: English Spanish Chinese French German Italian Sign Language
Other ____________________

Marital Status: Single Married Divorced Widowed Separated Life Partner

Race: African American/Black White Asian American Indian/Alaska Native Korean
Pacific Islander Asian Indian Chinese Filipino Japanese Vietnamese
Samoan Guamanian or Chamorro Rather Not Answer Other ______________________

Ethnicity: Hispanic/Latino Non-Hispanic/Latino Mexican Cuban
Mexican American Puerto Rican Other ______________
Rather Not Answer

Veteran Status: Yes No Decline

Homeless Status: Yes No Decline
Public Housing: Yes No Decline

Student: Yes, Full Time Yes, Part Time No
If yes, Provide School Name:

Current Primary Care Provider:
City/State/Phone:
Currently Treated by Home Health/SC House Calls/Hospice YES NO

Date of last visit with current provider:
Do you want to change current provider: YES NO

Current Pharmacy:
City/Phone #:

Do you have a provider preference? YES NO Requested Provider:

Emergency Contact (ages 19 and above):
Name: ____ Phone #: ________________________
Relationship:______________________________

How did you hear about Genesis Healthcare? Please select one: Referral; Referral Source: ______________________
Current Patient Social Media Advertisement Newspaper Article Community Event

Are you interested in serving on the Board of Directors for Genesis Healthcare? YES NO

Genesis
Healthcare, Inc.

PRIMARY INSURANCE

Insured's Name (If other than patient):		Insurance Company:
Address:		
SSN:	DOB:	Employer:

SECONDARY INSURANCE

Insured's Name (If other than patient):		Insurance Company:
Address:		
SSN:	DOB:	Employer:

NARCOTIC ACKNOWLEDGMENT

I (Print Name) ____ acknowledge that it has been explained to me that Genesis Healthcare, Inc. does not provide chronic narcotic pain management. This includes the use of narcotic medication as well as other supplemental controlled substances. I understand and agree that I will be referred to another clinic for pain management by that facility's physician.

____________________________________ ______________
Patient Signature/Patient Authorized Representative Date

____
Relationship to patient if patient unable to sign

ANSWERING MACHINE/VOICEMAIL MESSAGES

There may be times when our office is not able to reach you by telephone. With your permission, we would like to be able to leave messages on your home answering machine/cell phone voice mail. To comply with strict legal standards, a written release will allow us to leave a message on your answering machine. By signing below, you are authorizing us to leave messages on your answering machine at the telephone number you have given us in your record.

Patient/Patient Authorized Representative Signature: ____________________________________

Patient Name (Print): ____________________________ Date: ____________________________

Relationship to Patient if unable to Sign: ____

HIPAA AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Some patients prefer other individuals, especially family members, be allowed access to their medical information. To comply with strict legal standards, a written release is required to allow another person access to your medical records. This release grants permission to individual(s) listed below to: Make or confirm appointments, have access to x-ray and laboratory findings, pick up sample medications, be made aware of your diagnosis, prognosis, and treatment plans, and serve as your emergency contact. This permission applies to telephone and answering machine messages as well as other means of communication.

Patient's Signature: ____ Date: ____________________________

Patient Print: ____

1. Designated Party: ____

Telephone: ______________________________ Relationship: ______________________________

CONSENT FOR TREATMENT AND AUTHORIZATION

I, the undersigned, do hereby authorize and consent to medical examinations, x-rays, blood tests, laboratory procedures, immunizations, therapeutic injections, invasive or surgical procedures and other medically appropriate services under the general or specific supervision of any member of the medical staff of Genesis Healthcare, Inc for the patient named on this form.
It is understood that this authorization is given in advance of any specified diagnosis, treatment or care being required but it is given to provide authority and power to render care by providers of Genesis Healthcare, Inc. in the exercise of her/his best judgment that they may deem advisable. I understand that state law requires physicians to report certain communicable diseases to the Health Department. SC Code Ann. Sec 44-29-10. Regulation 61-20.
I agree that if I leave a physician's office against the advice of my physician(s) of Genesis Healthcare, Inc and its personnel, they are released from responsibility or liability for any injuries or damages which may result from leaving against medical advice. I authorize a physician of Genesis Healthcare, Inc to test me for HIV antibodies or tuberculosis when the doctor or any employees are exposed to body fluids in a manner which may transmit human immunodeficiency virus (HIV), or infection of tuberculosis. In the event of such an exposure, you will be deemed to have consented to such testing, and to have consented to the release of the test results to the person(s) who may have been exposed.

Patient/Patient Authorized Representative Signature: ____________________________________

Patient Name (Print): ____________________________ Date: ____________________________

Relationship to Patient if unable to Sign: ____

Genesis Healthcare, Inc.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Please Fax Records to Attention: ____________________

I authorize the use and disclosure of my individual health information as described below. I understand that the information I authorize a person or entity to receive may be re-disclosed and no longer protected by federal privacy regulations. (Note: S.C. Law prohibits the re-disclosure of mental health records).

Patient's Name: ____________________ **Date Requested:** ____________________

DOB: ____________________ **Social Security #:** ____________________ **MR#:** ____________________

Person/Organization Disclosing the Information: ____________________

Person/Organization Receiving the Information (Checkall that Apply):

Organization	Phone	Fax
Pee Dee Health Care 201 Cashua St Darlington, SC 29532	Phone: (843) 393-7452	Fax: (843) 393-6210
Genesis Healthcare Darlington 115 Exchange St Darlington, SC 29532	Phone: (843) 393-9421	Fax: (843) 968-3473
Olanta Family Care 211 S Jones Rd Olanta, SC 29114	Phone: (843) 396-9730	Fax: (843) 396-9735
Lamar Family Care 301 W Main St Lamar, SC 29069	Phone: (843) 395-8400	Fax: (843) 395-8401
Walterboro Family Care & Pediatrics 830 Robertson Blvd. Walterboro, SC 29488	Phone: (843) 781-7428	Fax: (843) 781-7429
Genesis Healthcare Florence OB/GYN 1523 Heritage Ln Florence SC, 29505	Phone: (843) 673-9992	Fax: (843) 968-3466
Genesis Healthcare Florence Family Med & Urology 1523 Heritage Ln Florence SC, 29505	Phone: (843) 673-0900	Fax: (843) 968-3479
Lowcountry Pediatrics 99 Bridgetown Rd, Goose Creek, SC 29445	Phone: (843) 572-3300	Fax: (833) 771-2207

Information for Treatment Period: From (Date): ____________________ **To (Date):** ____________________

__Office Notes __Hospital Notes __Laboratory Test __Consults __Radiology Reports __Ancillary Testing Reports
__Other (please specify) ____________________

Purpose(s): __Insurance __Legal Investigation __Disability Evaluation __Continued Care
Other: ____________________

OR __ I may request my information be released to me to exercise my right to access and obtain a copy of my PHI.

A. I understand that PHI may include records disclosed by health care providers and facilities that previously provided treatment to me.

B. I understand that PHI may include information and records protected under Federal Law (such as alcohol and drug abuse treatment) and/or State Law (such as mental health, AIDS, or HIV).

C. I understand that I may revoke this Authorization at any time. However, the revocation will not apply to PHI that has already been used or disclosed pursuant to this authorization. Contact the Compliance Officer to initiate the revocation process.

D. I understand my treatment by Genesis Healthcare Inc. is not conditioned upon whether I provide authorization for the requested use or disclosure of my PHI.

E. I understand that the 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 privacy standards.

I have read and understand this Authorization. I certify that I am the Patient listed above or a person authorized to permit release of records on the Patient's behalf. I hereby release Genesis Healthcare, Inc from any liability or damages arising in connection with or related to the use and/or disclosure of my protected health information pursuant to this Authorization.

____________________ ____________________ ____________________
Patient Name — Print | Patient Signature | Date

____________________ ____________________ ____________________
Authorized Representative | Relationship to Patient | Telephone Number

PATIENT FINANCIAL SELF-ATTESTATION AGREEMENT/ACKNOWLEDEGMENT

Patient Attestations (please initial)

_____ If my application is approved, I request all my medications be filled by a GHC pharmacy.

_____ I have the freedom to have my prescriptions filled at any pharmacy and voluntarily choose to use the services of Professional Pharmacy and understand that I can choose another pharmacy whenever I wish by notifying GHC in writing.

_____ I acknowledge that I have the freedom of choice to request brand-named medications as my preferred medication, when available, pursuant to South Carolina Law and I request that my prescriptions be filled using brand name drugs when available. This statement and request remain in full force and effect until I request otherwise, in writing.

_____ I acknowledge that GHC may obtain Prior Authorizations for brand name medications as authorized by me in this document.

_____ I agree and request that GHC process all manufacturer coupons on my behalf.

_____ I authorize GHC to deliver or mail my prescriptions to me in the event I am unable to pick them up;

_____ I agree to take all medication as prescribed and will notify GHC immediately in the event I am unable to follow prescribed medication instructions.

_____ That any self-referral to a non-GHC provider be added to my GHC medical record and the provider to my GHC care team, so that the responsibility of care remains with GHC.

_____ I will actively participate in any programs prescribed by my physicians such as Case Management, Disease Management, Preventive Care, wellness programs, and other such programs and/or services; and

_____ I certify under penalty of law based on information and beliefs formed after reasonable inquiry, the statements contained in this document are accurate and complete.

I attest that the above information provided to GHC is true and accurate.

Patient/Patient Authorized Representative Signature: ______________________________

Patient Name (Print): ______________________________ Date: ______________________

Relationship to Patient if unable to Sign: ______________________________