Genesis Healthcare, Inc.

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 ☐ Female-to-Male/Transgender Male ☐ Male-to-Female/Transgender Female ☐ Gender Non-Conforming/Neither Male nor Female ☐ Other_____

Sexual Orientation ☐ Bisexual ☐ Lesbian/Gay/Homosexual ☐ Straight/Heterosexual ☐ Unknown ☐ Rather Not Disclose ☐ Other_____

Insured's Language: ☐ English ☐ Spanish ☐ Chinese ☐ French ☐ German ☐ Italian ☐ Sign Language ☐ Other_____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Life Partner ☐ Unknown

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:

Date of last visit with current provider:

City/State/Phone:

Do you want to change current provider: ○ YES ○ NO

Currently Treated by Home Health/SC House Calls/Hospice ○ 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 (Check All that Apply):

☐ 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 1523 Heritage Ln Florence SC, 29505	Phone: (843) 673-9992	Fax: (843) 673-9996
☐ 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