

PATIENT INFORMATION

Last Name	First Name	M.I.	Social Security #
Address			
Home Telephone	Cell Phone	Date of Birth (MM/DD/YYYY)	Age
Email:	<input type="checkbox"/> Yes! Sign me up for Genesis email updates.	Consent to Call <input type="checkbox"/> Yes <input type="checkbox"/> No	
		Consent to Text <input type="checkbox"/> Yes <input type="checkbox"/> No	
Please Check All That Apply			
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female			
Insured's Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Chinese <input type="checkbox"/> French <input type="checkbox"/> German <input type="checkbox"/> Italian <input type="checkbox"/> Sign Language <input type="checkbox"/> Other _____			
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Life Partner			
Race: <input type="checkbox"/> African American/Black <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Korean <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Asian Indian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Vietnamese <input type="checkbox"/> Samoan <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Rather Not Answer <input type="checkbox"/> Other _____			
Ethnicity: <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Latino <input type="checkbox"/> Mexican <input type="checkbox"/> Cuban <input type="checkbox"/> Mexican American <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Other _____ <input type="checkbox"/> Rather Not Answer		Veteran Status: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Decline Agricultural Status: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Decline	
Homeless Status <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Decline Public Housing <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Decline		Student: <input type="checkbox"/> Yes, Full Time <input type="checkbox"/> Yes, Part Time <input type="checkbox"/> 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: <input type="checkbox"/> YES <input type="checkbox"/> NO	
Currently Treated by Home Health/SC House Calls/Hospice <input type="checkbox"/> YES <input type="checkbox"/> NO			
Current pharmacy:			
City/Phone #:			
Do you have a provider preference? <input type="checkbox"/> YES <input type="checkbox"/> NO Requested Provider:			
Emergency Contact (ages 19 and above):			
Name: _____		Phone #: _____	
Relationship: _____			
How did you hear about Genesis Healthcare? Please select one: <input type="checkbox"/> Referral; Referral Source: _____ <input type="checkbox"/> Current Patient <input type="checkbox"/> Social Media Advertisement <input type="checkbox"/> Newspaper Article <input type="checkbox"/> Community Event			
Are you interested in serving on the Board of Directors for Genesis Healthcare? <input type="checkbox"/> YES <input type="checkbox"/> NO			

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/VOICE MAIL 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: _____

Patient Financial Self-Attestation Agreement/Acknowledgement

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: _____