Genesis Healthcare, Inc.

# New Patient Application - Dental

## DENTAL PATIENT INFORMATION

| Last Name | First Name | M.I. | Social Security # |
|---|---|---|---|
| | | | |

**Address**

| Home Telephone | Cell Phone | Date of Birth (MM/DD/YYYY) | 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

**Agricultural 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:**

**Date of your last dental exam:**

**Date of last dental x-rays:**

**Current Primary Care Provider:**

**City/State/Phone**

**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

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## PRIMARY DENTAL INSURANCE

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

## SECONDARY DENTAL INSURANCE

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

## MEDICARE PATIENTS – LIFETIME AUTHORIZATION TO PERMIT PAYMENT OF MEDICARE BENEFITS TO PROVIDER, PHYSICIANS, AND PATIENT

I certify that the information given to me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration, or its intermediaries or carriers any information needed for this or related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for covered Medicare services to the physician. As my healthcare provider, I appoint Genesis Healthcare, Inc[1] to act as my representative in connection with any claim or asserted right under Title XVIII of the Social Security Act and related provisions of Title XI of the Act and authorize Genesis Healthcare, Inc make any claims, present or elicit evidence, obtain appeals information, and receive notice in connection with my claim, appeal, grievance. I further authorize Genesis Healthcare, Inc to release any and all medical and billing information to any health care provider involved in my treatment and to any health care facility directly or indirectly involved in my treatment for purposes including, but not limited to, billing, collection, quality assurance or risk management activities, or defense of litigation or anticipated litigation and to any insurance company, health maintenance organization or other entity which is directly or indirectly responsible for payment or review of services provided by Genesis Healthcare, Inc.

Patient/Patient Authorized Representative Signature: _____

Patient Name (Print): _____ Date_____

Relationship to Patient if Unable to Sign: _____

Appointed Representative: Genesis Healthcare, Inc.

## FINANCIAL STATEMENT

I understand and agree that regardless of my insurance coverage, I am ultimately responsible for payment of any charges for professional services rendered. I understand that I will be ultimately responsible for collection fees and any attorney fees should my account be placed with a collection agency due to nonpayment of my account. I certify that the information I have given is true and correct to the best of my knowledge. If I have health insurance, Genesis Healthcare, Inc. will file on my behalf, but it is my responsibility to see that my health insurance policy pays the benefits provided under said policy. If there is a change in family member status, it is my responsibility to give the information, in writing, to Genesis Healthcare, Inc. as I am responsible for all charges incurred for my family members. I request that payment for professional service rendered be made directly to Genesis Healthcare, Inc. I permit a copy to be used in place of the original.

Patient/Patient Authorized Representative Signature: _____

Patient's Name (Print): _____ Date: _____

Relationship to Patient if Unable to Sign: _____

Genesis certifies that, as the Appointed Representative, the healthcare organization has not been disqualified, suspended, or prohibited from practice before the Department of Health and Human Services (HHS) and has not been disqualified from acting as a party's representative. Genesis, as the Appointed Representative of beneficiaries, waives the right to charge and collect a fee for representing the beneficiary before the Secretary of HHS. Genesis, as the Appointed Representative, also waives the right to collect payment from the beneficiary for items or services on appeal if a determination of liability under §1879(a)(2) of the Act is at issue.

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## MINOR PATIENTS ONLY (0-18 years)

**Mother** (if the address and phone numbers are the same as the patient, please indicate same.)

Full Name: _____ Phone: _____

Home Address: _____

Employer: _____ Phone: _____

**Father** (if the address and phone numbers are the same as the patient, please indicate same.)

Full Name: _____ Phone: _____

Home Address: _____

Employer: _____ Phone: _____

Please list any caregivers that you authorize to obtain medical care for your child in your absence:

| Alternate Caregiver Name | Relationship to Minor | Phone Number |
|---|---|---|
| | | |
| | | |
| | | |

**Emergency Contact other than caregiver**: _____ **Phone**: _____

**Relationship to Minor**: _____

With my permission, I hereby authorize the above individuals to consent to all medical care and attention which is deemed necessary and appropriate by a health care provider at Genesis Healthcare, Inc for this minor. This includes, but is not limited to emergency services, lab tests, procedures, and immunizations. The listed individuals are given authority to discuss and change appointments, financial or insurance details, and clinical information including labs/tests.

Parent/Legal Guardian Signature: _____

Parent/Legal Guardian Name (Print): _____ Date: _____

**List all siblings at this practice:**

| Full Name | DOB | Age |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

Genesis Healthcare, Inc.

# HISTORY INTAKE

## Dental History

| | | | | | |
|---|---|---|---|---|---|
| Do your gums bleed when you brush or floss? | Yes | No | Are you experiencing any dental pain or discomfort? | Yes | No |
| Are your teeth sensitive to cold, hot, sweets, or pressure? | Yes | No | Do you grind your teeth? | Yes | No |
| Is your mouth dry? | Yes | No | Do you have sores or ulcers in your mouth? | Yes | No |
| Have you had any periodontal (gum) treatments? | Yes | No | Do you wear dentures or partials? | Yes | No |
| Have you had orthodontic (braces) treatment? | Yes | No | Have you had injury to your head or mouth? | Yes | No |
| Have you had any problems with previous dental treatment? | Yes | No | Do you have any clicking, popping, or discomfort in your jaw? | Yes | No |
| Do you have earaches or neck pains? | Yes | No | Do you use tobacco (smoking, snuff, chew) | Yes | No |
| Do you have an artificial heart valve? | Yes | No | Have you had a heart infection (endocarditis)? | Yes | No |
| Have you ever had a heart attack (myocardial infa | Yes | No | Other: | | |

How do you feel about your smile?

## Medical History

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Anemia | Yes | No | Gout | Yes | No | Osteoporosis | Yes | No |
| Anxiety | Yes | No | Heartburn | Yes | No | Prostate problems | Yes | No |
| Arthritis | Yes | No | Heart Problems | Yes | No | Seasonal Allergies | Yes | No |
| Asthma | Yes | No | High Blood Pressure | Yes | No | Seizures | Yes | No |
| Autoimmune Disease | Yes | No | High Cholesterol | Yes | No | Skin Problems | Yes | No |
| Back Problems | Yes | No | Infections (HIV, TB, etc) | Yes | No | Sleep Problems/Apnea | Yes | No |
| Bone Problems | Yes | No | Kidney Problems | Yes | No | Stomach/Intestine problems | Yes | No |
| Clotting Disorder | Yes | No | Lung Problems | Yes | No | Stroke | Yes | No |
| Dementia | Yes | No | Migraines | Yes | No | Substance use | Yes | No |
| Diabetes | Yes | No | Mental Disorders | Yes | No | Thyroid Disease | Yes | No |
| Fibromyalgia | Yes | No | Nerve/Muscle Disease | Yes | No | Other: | Yes | No |

## Medication History

| List all Medications (including vitamins, herbs, OTC): |
|---|
| 1. |
| 2. |
| 3. |
| 4. |
| 5. |
| 6. |
| 7. |
| 8. |
| 9. |

## Allergy History

| List all Allergies (medication, food, materials) |
|---|
| 1. |
| 2. |
| 3. |
| 4. |
| 5. |
| 6. |
| 7. |
| 8. |
| 9. |

## Surgical History

| List of All Surgeries (when & where): |
|---|
| 1. |
| 2. |
| 3. |
| 4. |
| 5. |

## Hospital History

| List of Most Recent Hospital Stays (when & where): |
|---|
| 1. |
| 2. |
| 3. |
| 4. |
| 5. |

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## 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 dental examinations, x-rays, blood tests/laboratory procedures, 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 damage 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:** _____

**Relationships to Patient if Unable to Sign:** _____

## PATIENT RESPONSIBILITIES

- Providing the physician and his/her staff with complete and accurate information concerning your health, including any allergies or sensitivities.
- Providing your physician with a current list of your medications, any over-the-counter products and/or dietary supplements.
- Providing accurate and complete information regarding present complaints, hospitalizations, and past illnesses.
- Providing the physician and his/her staff with any changes in your medical condition.
- Following the treatment plan prescribed by your physician.
- Keeping your appointments with your physician and notifying physician when you are unable to do so.
- Providing a responsible adult to transport you home from the facility and to remain with you for 24 hours after a procedure if required by your physician.
- Informing your physician if you have a living will, advanced directive, or medical power of attorney that could affect your care.
- Being considerate of the rights of other patients and clinic personnel.
- Accepting personal financial responsibility for any charges not covered by your insurance.
- Personally choose to refuse treatment, but understand you are responsible for your decisions if you do not accept treatment or do not follow your physician's instructions.
- Changing your physician if you determine it is necessary or requesting a second opinion.

## OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your medical information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your medical information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect 04/14/2003 and will remain in effect until we replace it. We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all medical information that we maintain, including medical information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and make the new notice available upon request.

## WHO WILL FOLLOW THIS NOTICE

This notice describes our facility's practices and those participants listed below in our organized health care arrangement. As such, we may share your medical information with each other as needed for treatment, payment or health care operations relating to our organized health care arrangements.

**This notice does not imply any joint venture or any other special association or legal relationship between the facility and its medical staff. This notice is an administrative tool permitted by federal law allowing the facility and medical staff to tell you about common privacy practices.**

Along with the facility, the following participate in our organized health care arrangement:

- Members of our medical staff and their employees or workforce who provide services or support to the physician at the facility.
- Our employed physicians and their office staff.

## USES AND DISCLOSURES OF CERTAIN TYPES OF MEDICAL INFORMATION

For certain types of medical information, we may be required to protect your privacy in ways stricter than we have discussed in this notice. We must abide by the following rules for our use or disclosure of certain types of your medical information for purposes of use or disclosure of your medical information:

**Sexually Transmitted Disease Information:** We may not disclose HIV information unless required by law, pursuant to an authorization or the disclosure is to you or your personal representative; or, to medical personnel to the extent necessary to protect the health or life of any person. SC Code Ann. 44-29-135(d)

**Genetic Information:** We may only disclose your genetic information to for the following purposes: as necessary for the purpose of a criminal or death investigation, or a criminal or judicial proceeding or inquest, or a child fatality review; pursuant to court order; to law enforcement or government agency for purpose of identifying a person under appropriate circumstances or a dead body; or to other persons as may be required by law. SC Code Ann. Sec 38-93-40

**Alcohol and Drug Abuse Information:** We may not disclose your medical information that contains alcohol and drug abuse information except to you, your personal representative or pursuant to an authorization or as may otherwise be allowed by law. SC Code Ann. 44-22-100

We use and disclose medical information about you for treatment, payment, and health care operations. For example:

**Treatment:** We may use or disclose your medical information to a physician or other health care provider within our clinics to provide treatment to you. We may use or disclose medical information to specialists or other health care providers to whom you have been referred.

## USES AND DISCLOSURES OF MEDICAL INFORMATION

**Payment:** We may use and disclose your medical information to obtain payment for services we provide to you. We may disclose your medical information to another health care provider or entity subject to the federal and state Privacy Rules so they can obtain payment.

**Health Care Operations:** We may use and disclose your medical information in connection with our health care operations. These uses are necessary to make sure that all our patients receive quality care.

Some examples are:

- Review of our treatment or services to evaluate the performance of our staff providing your care.
- Sending you a satisfaction survey.
- Review of information about many of our patients to determine if additional services should be added or perhaps are no longer needed.
- Information may be given to our doctors, nurses, medical and health care students, and other personnel to be used for education and learning purposes.
- We may remove information that identifies you from the medical information so others may use it for studies in health care delivery without learning who the patients are; and
- We may disclose your medical information to another provider who has a relationship with you and is subject to the same Privacy rules, for their health care operation purposes.

**On Your Authorization:** You may give us written authorization to use your medical information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your medical information for any reason except those described in this notice.

**Appointment Reminders:** We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or medical care at the facility.

**To Your Family and Friends:** With your permission, we may disclose your medical information to a family member, friend, or other person to the extent necessary to help with your health care or with payment for your health care. If you are not present, or in the event of your incapacity or an emergency, we will disclose your medical information based on our professional judgment of whether the disclosure would be in your best interest.

We will also use our professional judgment and our experience with common practice to allow a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of medical information.

**By Law or Special Circumstances:** We may use or disclose your medical information as authorized by law for the following purposes deemed to be in the public interest or benefit:

- As required by law.
- For public health activities, including disease and vital statistic reporting, child abuse reporting, FDA oversight, and to employers regarding work-related illness or injury.
- To report adult abuse, neglect, or domestic violence.
- To health oversight agencies.
- In response to court and administrative orders and other lawful processes.
- To law enforcement officials after receiving subpoenas and other lawful processes, concerning crime victims, suspicious deaths, crimes on our premises, reporting crimes in emergencies, and for purposes of identifying or locating a suspect or other person.
- To coroners, medical examiners, and funeral directors.
- To organ procurement organizations.
- To avert a serious threat to health or safety.
- In connection with certain research activities.
- To the military and to federal officials for lawful intelligence, counterintelligence, and national security activities.
- To correctional institutions regarding inmates.

**Health-Related Benefits and Services:** We may use your medical information to contact you with information about health-related benefits and services or about treatment alternatives that may be of interest to you. We may disclose your medical information to a business associate to assist us in these activities. We may use or disclose your medical information to encourage you to purchase or use a product or service by face-to-face communication or to provide you with promotional gifts.

Genesis Healthcare, Inc.

## YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU

**Right to Inspect and Copy:** You have the right to look at or get copies of your medical information, with limited exceptions. You must make a request in writing to obtain access to your medical information. You may obtain a form to request access by using the contact information listed at the end of this notice. You may also request access by sending us a letter to the address at the end of this notice. As permissible by South Carolina Law, if you request copies, we will charge you a fee for copying and postage if you want the copies mailed to you. Contact us using the information listed at the end of this notice for a full explanation of our fee structure. SC Code Ann. Sec. 44-115-80

We may deny your request to inspect and copy in very limited circumstances as allowed by law. If you are denied access to your medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by the facility will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

**Disclosure Accounting:** You have the right to receive a list of instances in which we or our business associates disclosed your medical information for purposes other than treatment, payment, health care operations, as authorized by you, and for certain other activities, since April 14, 2003. You must make a request in writing to request a listing of disclosures. You may obtain a form to request the accounting by using the contact information at the end of this notice. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.

**Restriction:** You have the right to request that we place certain restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). Any agreement to additional restrictions must be in writing. You may obtain a form to request additional restrictions on the use or disclosure of your medical information by using the contact information listed at the end of this notice. We will not be bound to the restrictions unless our agreement is signed by you and the appropriate facility representative.

**Confidential Communication:** You have the right to request that we communicate with you about your medical information by alternative means or to alternative locations. For example, you might request that we contact you at work or by mail. You must make your request in writing. You may obtain a form to request alternative communications by using the contact information listed at the end of this notice. We must accommodate your request if it is reasonable, specifies the alternative means or location, and provides satisfactory explanation how payments will be handled under the alternative means or location you request.

**Amendment:** If you feel that medical information, we have about you is incorrect or incomplete, you may ask us to amend the information. Your request must be in writing, and it must explain why the information should be amended. You may obtain a form to request an amendment by using the contact information listed at the end of this notice. We may deny your request if we did not create the information, you want amended and the individual who provided the information remains available or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement to be attached to the information you wanted amended. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people you name, of the amendment and to include the changes in any future disclosures of that information.

**Electronic Notice:** If you receive this notice on our website or by electronic mail (e-mail), you are entitled to receive this notice in written form. Please contact us using the information listed at the end of this notice to obtain this notice in written form.

If you want more information about our privacy practices or have questions or concerns, please contact Genesis Healthcare Inc. using the information listed at the end of this notice.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your medical information or in response to a request you made to amend or restrict the use or disclosure of your medical information or to have us communicate with you by alternative means or at alternative locations, you may notify us of your concerns by using the contact information listed at the end of this notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request. We support your right to the privacy of your medical information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact: COMPLIANCE
Telephone: 843-393-7452
Address: 201 Cashua Street, Darlington, SC 29532

**NOTICE OF PRIVACY PRACTICE**

I have received GHC's Notice of Privacy Practices and agree to the terms regarding the use and disclosure of medical information.

**Patient/Patient Authorized Representative Signature: _____**
**Patient Name (Print): _____**

**Relationship to Patient if Unable to Sign: _____ Date: _____**

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):**

| Location/Department | Address | Phone | Fax |
|---|---|---|---|
| □ Pee Dee Health Care | 201 Cashua St. Darlington, SC 29532 | 843.393.7452 | 843.393.6210 |
| □ Genesis Healthcare, Darlington (Behavioral Health) | 115 Exchange St. Darlington, SC 29532 | 843.393.9421 | 843.968.3473 |
| □ Olanta Family Care | 211 S Jones Rd Olanta, SC 29114 | 843.396.9730 | 843.396.9735 |
| □ Lamar Family Care | 301 W Main St. Lamar, SC 29069 | 843.395.8400 | 843.395.8401 |
| □ Genesis Healthcare Florence OB/GYN | 1523 Heritage Ln. Florence, SC 29505 | 843.673.9992 | 843.968.3466 |
| □ Genesis Healthcare Florence Family Medicine and Urology | 1523 Heritage Ln. Florence, SC 29505 | 843.673.0900 | 843.968.3479 |
| □ Lowcountry Pediatrics | 99 Bridgetown Rd. Goose Creek, SC 29445 | 843.572.3300 | 833.771.2207 |
| □Walterboro Family Care & Pediatrics | 830 Robertson Blvd. Walterboro, SC 29488 | 843.781.7428 | 843.781.7429 |
| □ Walterboro Family Care & Pediatrics Dental | 830 Robertson Blvd. Walterboro, SC 29488 | 843.584.4311 | 843.584.4312 |
| □ Walterboro Family Care Endocrinology | 830 Robertson Blvd. Walterboro, SC 29488 | 843.538.8585 | 843.538.4777 |

**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/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: _____**