ADVANCED SPINE
AND NEUROSURGICAL ASSOCIATES
Self Medical Group

Directions and Map

You have been scheduled an appointment with Advanced Spine and Neurosurgical Associates.

Appointment Date: _____ **Time:** _____

With: _____

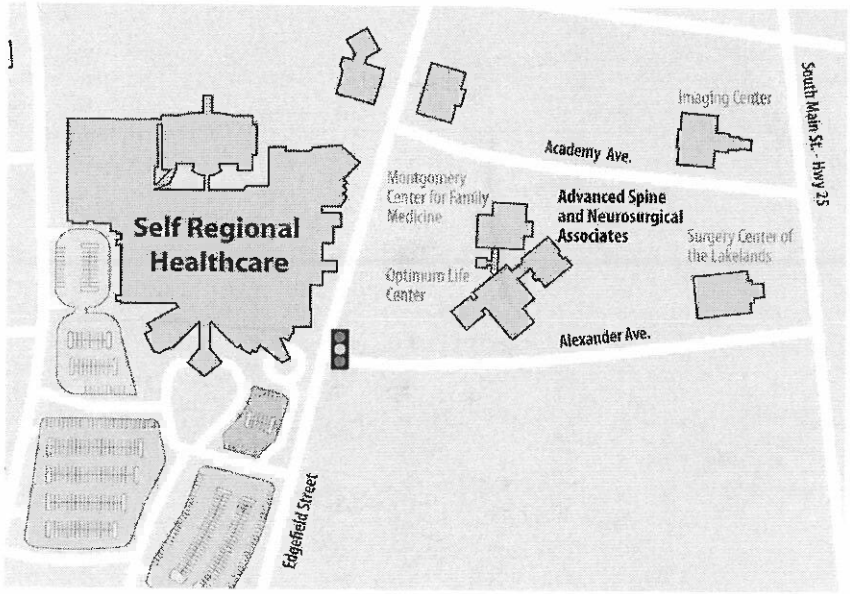
Location: 115 Academy Avenue, Greenwood, SC 29646

Phone: (864) 725-7780

Academy Avenue is located off of South Main Street (Highway 25 Business). The road is between the Imaging Center and Surgery Center of the Lakelands, one block south of McDonald's.

Self pay new patients will have to pay $100 and **established self pay patients** will pay $50 due at the time of appointment. You may be required to pay an additional $20 if a urine drug screen is ordered.

Please bring with you: All medications, insurance information and MRI disc (if available).



Patient Registration Form

__/__/____
Today's Date

Self Medical Group

Patient Demographics

Social Security # | Legal Last Name | Legal First Name | Middle Initial | Preferred First Name

Permanent Address | Apt. # | City | State | ZIP

Home Phone | Cell Phone | Preferred Provider / Primary Care Physician

Birth Date | Language | Email Address

Gender ❑ Male ❑ Female | Marital Status ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Race ❑ Black/African American ❑ Hispanic ❑ White ❑ Other _____ | Ethnicity ❑ Hispanic/Latino ❑ Non-Hispanic/Non-Latino ❑ Unknown

Emergency Contact Information

Contact Name | Relationship to Contact | Contact Phone #

Contact Address | Apt. # | City | State | ZIP

Patient Employment Information

Employer | Employment Address | City | State | ZIP

Occupation | Employment Contact | Phone # | Fax #

Employment ❑ Part Time ❑ Full Time ❑ Not Employed ❑ Self Employed ❑ Retired ❑ Disabled

Student ❑ Part Time ❑ Full Time ❑ Not a Student ❑ Military

Responsible Party's Information

Responsible Party's Legal Name | Social Security # | Date of Birth

Responsible Party's Address | Apt. # | City | State | ZIP

Medical Insurance Policy Holder Information

Please present your insurance card(s) & ID with this form.

PRIMARY
Legal Name | Social Security #
Address | City/State/ZIP
Phone # | Relationship to Patient | Birth Date
❑ Male ❑ Female Employer: _____

SECONDARY
Legal Name | Social Security #
Address | City/State/ZIP
Phone # | Relationship to Patient | Birth Date
❑ Male ❑ Female Employer: _____

Authorization to Release Information: I hereby authorize Self Medical Group (SMG) to release information acquired in the course of my medical treatment to my insurance companies. I also authorize payment directly to SMG for medical treatment received and claims submitted on an assigned basis.

I Further Understand and agree that: By signing below, either personally or through the person legally empowered to give consent, I authorize SMG, its employees, agents and other affiliates to provide general care for this and all subsequent requests for care. SMG shall also be entitled to the recovery of all its expenses, including all collection fees, attorney's fees and other legal costs, that it incurs in connection with the collection or recovery of an unpaid balance on my account and that these costs of collection shall be immediately due and payable upon demand.

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? ❑ YES ❑ NO

IF YES, WHOM? _____

Signature _____ **Date** _____

SELF REGIONAL HEALTHCARE

Patient Financial Agreement

PLEASE READ THOROUGHLY AND SIGN BELOW.

In consideration of receiving services from a Self Regional Healthcare (SRH) facility, you agree:

1. All services are provided to you with the understanding that you are responsible for the cost regardless of your insurance coverage. If you would like to know the cost of a service, please inquire prior to treatment. Please be aware that not all services are a covered benefit with different insurance companies. You are responsible for knowing what services are or are not covered. **KNOW YOUR BENEFITS.**
2. **On the date of service,** we will collect your deductible, co-pay, and payment for any uncovered services as well as the patient's portion as determined by insurance. We accept cash, check, debit card, and credit cards for MasterCard and Visa.
3. Your insurance policy is a contract between you, your employer, and the insurance company! We are NOT a party to that contract. **It is your responsibility to notify this office immediately if your insurance coverage or company changes. It is your responsibility to understand your coverage and benefits, including pre-certifications, referral and authorization requirements, and to be sure all insurance information is current.**
4. We will bill your insurance company as a courtesy, but you are still ultimately responsible for payment of all services you receive. If your insurance company does not respond within 30 days we will follow up with an inquiry on your behalf. If, however, your insurance does not respond within 60 days of claim submission, a statement will be sent to you. You should call your insurance to question why the claim is not paid. Our office will assist you only after you have contacted your insurance.
5. If your medical claim has not paid and your insurance company has not resolved your dispute you may register a complaint with the South Carolina Department of Insurance. Our office will do everything we can to assist you however; you must understand you cannot delay payment while you are awaiting the outcome of your complaint.
6. Any unpaid charges over 90 days old will be considered for an outside collection agency. You are responsible for any collection fees, legal fees, or court costs incurred in the collections process. This agency will report your failure to pay to the THREE (3) national credit reporting agencies.
7. We do understand that temporary financial problems may affect timely payment. We encourage you to communicate any such problems so that we can assist you in the management of your account. Please call (864)725-7491 Monday through Friday from 8:30 a.m. to 5:00 p.m. for account management.
8. **Non-Insured:** If you do not have medical insurance, you will be responsible for a minimum payment at the time of service for the service to be received that day, as well as any previous outstanding balance. If a procedure is necessary, payment may be required prior to the procedure. We offer a 20% discount for payment in full at time of service.
9. We have facility and administration charges for blood draw, surgical tray, durable medical equipment, etc. These are services offered for patient convenience and are not billable to your insurance company; they are your full responsibility.
10. Returned checks are subject to a $25.00 return check fee.
11. **Release of Information:** I assign benefits of my medical insurance contract, Medicaid or Medicare to SRH and authorize payment directly to SRH. I authorize SRH to release medical information to payers as required for payment of claims for medical services.
12. I authorize and direct Self Regional Healthcare to apply any overpayment to other Self Regional Healthcare accounts of mine, my spouse, or my children. Other such accounts include, but may not be limited to, those of our affiliates Self Medical Group and Edgefield County Healthcare.

We are committed to providing you with the best possible care and we are willing to discuss our professional fees at any time. Your clear understanding of our Financial Policy is important to our relationship. Please ask if you have any questions about our fees, Financial Policy, or your financial responsibility.

I have read and understand this Patient Financial Agreement.

_____

Patient/Guardian Signature Date

ADVANCED SPINE
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Patient Name: _____ **Patient DOB:** _____

Was this related to an accident? Yes No

If yes, please indicate below:

Auto WE DO NOT FILE AUTOMOBILE ACCIDENTS OR BILL THIRD PARTIES. You may pay cash, check, credit card or file with your private insurance.

Work Be advised all workers compensation injuries must be approved prior to services being rendered by Advanced Spine & Neurosurgical Associates. It is the patient's responsibility to provide us with this information. Failure to provide us with the appropriate information may result in a delay in your treatment.

WORKMAN'S COMPENSATION INFORMATION (at time of injury)

Name of WC Insurance Company Street Address City/State/Zip

_____

Nurse Case Manager: _____ Phone Number: _____

Claim/Case Number: _____

Years Employed: _____ Date of Injury: _____

Are you represented by an attorney? Yes No

If yes, what type of representation: _____

If yes, is this related to a disability claim? _____

If yes to either, lawyers name, address, telephone#: _____

_____

*****NOTE*****

It is very important for you to provide the correct information at the time services are being rendered. Notification of a work related injury after presenting your private pay insurance is considered insurance fraud. The physicians at Advanced Spine & Neurosurgical Associates would appreciate your complete honesty when it comes to an injury you may have received prior to your visit with them or if you have an attorney representing you for any reason.

Patient/Guardian Signature: _____ Date: _____

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Patients who fail to keep appointments or fail to cancel appointments in a timely manner cost the healthcare system thousands of dollars in lost revenue each year. To ensure the most efficient and cost-effective management of our physician offices, it is necessary to actively manage patient appointments and those patients who fail to keep or cancel appointments.

It is Self Medical Group policy that **patients who fail to keep** (no show) **scheduled appointments** or fail to cancel appointments at least 24 hours in advance **more than 3 times** in a rolling 12-month period will be considered "chronic no show" patients and will be subject to dismissal from care by the respective provider and/or practice.

If you arrive more than **15 minutes late** for your scheduled appointment, your appointment may be rescheduled.

I HAVE READ AND UNDERSTAND THIS POLICY

_____ Date: _____

Signature of Patient or Patient's Representative

_____

Relationship to Patient

Medications, Allergies and Medical Conditions

__/__/____
Today's Date

Self Medical Group

Patient Demographics

Patient Name _____ Birth Date _____

Pharmacy Name _____ Pharmacy Phone _____ Pharmacy Street / City / State _____

Primary Care Physician _____ Referring Physician _____

Do you have an Advance Directive? ❑ Yes ❑ No

Medications *Please list all medications, both prescriptions and over-the-counter, that you are presently taking.*

Medication	Dose/ Strength	How often do you take this medication?	Reason for taking this medication?	Who prescribed this medication for you?

Allergies *Please list all allergies and the reaction that occurred.*

Allergic to?	Describe reaction that occurred:

Medical/Surgical History *Please list **all** medical conditions and previous surgeries.*

_____

_____

_____

_____

_____

Family Medical History

	Illness/Condition	Deceased?	Cause of Death
Father		❑ Yes ❑ No	
Mother		❑ Yes ❑ No	
Grandparents		❑ Yes ❑ No	
Sisters/Brothers		❑ Yes ❑ No	

Social History

	Type	Amount	Years Quit?
Alcohol			
Caffeine			
Recreational drugs			
Tobacco products			

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Patient Name_____ Patient DOB_____

Please check yes or no if you have RECENTLY noticed any of the following with your health:

	YES	NO		YES	NO
CONSTITUTION			**RESPIRATORY**		
Activity Change			Apnea		
Appetite Change			Chest tightness		
Chills			Choking		
Diaphoresis (excessive sweating)			Cough		
Fatigue			Shortness of breath		
Fever			Stridor		
Unexpected weight change			Wheezing		
HEAD, EARS, NOSE, THROAT			**CARDIO**		
Congestion			Chest pain		
Dental problem			Leg swelling		
Drooling			Palpitations		
Ear discharge					
Ear pain			**GASTROINTESTINAL**		
Facial swelling			Abdominal distention		
Hearing loss			Abdominal pain		
Mouth sores			Anal bleeding		
Nosebleeds			Blood in the stool		
Postnasal drip			Constipation		
Rhinorrhea (runny nose)			Diarrhea		
Sinus pain			Nausea		
Sinus pressure			Rectal Pain		
Sneezing			Vomiting		
Sore throat					
Tinnitus (ringing in the ears)			**ENDOCRINE**		
Trouble swallowing			Cold intolerance		
			Polydipsia (excessive thirst)		
EYES			Polyphagia (excessive hunger)		
Eye discharge			Polyuria (frequent urination)		
Eye itching					
Eye pain			**ALLERGY/IMMUNO**		
Eye redness			Environmental allergies		
Photophobia (sensitivity to light)			Food allergies		
Visual disturbance			Immunocompromised		

Patient Name_____ **Patient DOB**_____

Please check yes or no if you have RECENTLY noticed any of the following with your health:

	YES	NO
GENITOURINARY		
Difficulty urinating		
Dysuria (painful urination)		
Enuresis (urinary incontinence)		
Flank pain		
Frequency		
Genital sore		
Hematuria (blood in urine)		
Penile discharge		
Penile pain		
Penile swelling		
Scrotal swelling		
Testicular pain		
Urgency		
Urine decreased		
MUSCULOSKELETAL		
Arthralgia (inflammation)		
Back pain		
Gait problem		
Joint swelling		
Myalgia (muscle aches)		
Neck pain		
Neck stiffness		
SKIN		
Color change		
Pallor		
Rash		
Wound		

	YES	NO
NEUROLOGICAL		
Dizziness		
Facial asymmetry		
Headaches		
Light-headedness		
Numbness		
Seizures		
Speech difficulty		
Syncope		
Tremors		
Weakness		
HEMATOLOGIC		
Adenopathy (swollen lymph nodes)		
Bruises/bleeds easily		
PSYCHIATRIC		
Agitation		
Behavior problems		
Confusion		
Decreased concentration		
Dysphoric mood		
Hallucinations		
Hyperactive		
Nervous/anxious		
Self injury		
Sleep disturbance		
Suicidal ideas		