NAME: _____
LAST FIRST MIDDLE

ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____

SEX: _____ AGE: _____ BIRTHDAY: _____ MARITAL STATUS: S M D X W SP

PHONE: _____ CELL: _____
SOCIAL SECURITY NUMBER: _____

EMPLOYED BY: _____ OCCUPATION: _____
BUISNESS ADDRESS: _____ PHONE # _____

SPOUSE NAME: _____ SPOUSE SOCIAL SECURITY: _____
EMPLOYED BY: _____ PHONE: _____

INSURANCE: _____ CONTRACT NUMBER: _____
GROUP #: _____ SUBSCRIBER # _____
ADDRESS: _____

MEDICARE# _____ MEDICAID: _____

WHICH DRUG STORE DO YOU USE? _____ PHONE: _____

ASSIGNMENT OF INSURANCE BENEFITS

I hereby assign all payments for medical services provided to myself or my dependents to Carolina Medical Center. I understand that I am responsible for any amount not covered by insurance

_____ _____
Authorized signature of subscriber Date

PLEASE CIRCLE YES OR NO ANSWERS OR APPROPRIATE ANSWERS AND FILL IN ALL BLANKS.

ARE YOU? MARRIED SINGLE DIVORCED WIDOW SEPERATED

DO YOU SMOKE? YES OR NO IF YES HOW MUCH? _____

DO YOU DRINK? YES OR NO IF YES HOW MUCH? _____

HAVE YOU EVER BEEN IN ANY ACCIDENTS? YES OR NO IF YES WHEN? _____
WHERE?_____

DO YOU EXERCISE? YES OR NO IF YES WHAT KIND _____

DO YOU HAVE KIDS? YES OR NO BOYS_____ GIRLS_____

DO YOU HAVE BROTHERS OR SISTERS? BROTHER's _____ SISTERS_____

ARE YOU ALLERGIC TO ANYTHING? YES OR NO IF YES WHAT _____
WHAT SIDE AFFECTS DO YOU GET FROM THIS_____

HAVE YOU HAD ANY SURGERIES YES OR NO? IF YES WHAT TYPE _____
WHERE:_____ WHAT YEAR ? _____
HAVE YOU BEEN HOSPITALIZED YES OR NO? IF YES WHEN _____
YEAR_____WHERE? _____
ARE YOU WORKING? WORKING RETIRED DISABLED

ARE YOU? FULL TIME PART TIME NONE

HOW MANY HOURS DO YOU WORK? _____

EMAIL ADDRESS: _____

DO YOU HAVE A POWER OF ATTORNEY OR A LIVING WILL YES OR NO IF YES WHICH ONE _____

Family history
Please state who in your family **including yourself** who has the following conditions

Heart attack:_____
High blood pressure:_____
Stroke:_____
High cholesterol:_____
Lung disease:_____
Stomach ulcers:_____
Arthritis:_____
Cancer:_____
Bleeding disorder:_____
Anemia:_____
Diabetes:_____
Thyroid problems:_____
Alcohol or drug abuse:_____
Depression:_____

MEDICATION LIST

PLEASE LIST ALL MEDICATIONS

MEDICATION	STRENGTH	DOSAGE

CAROLINA MEDICAL CENTER
461 SPRUCE STREET
WALTERBORO SC 29488

CONSENT TO ACCESS PRESCRIPTION HISTORY

PRINT NAME:_____

CAROLINA MEDICAL CENTER PHYSICIANS USE AN ELECTRONIC MEDICAL RECORD THAT ALLOWS THEM TO ELECTRONICALLY SEND PRESCRIPTIONS DIRECTLY TO PHARMACIES. OUR SYSTEM ALSO ALLOWS OUR PHYSICIANS TO ACCESS A LIST OF PRESCRIPTIONS FILLED BY THEIR PATIENTS WITHIN THE PAST 2 YEARS. REVIEWING THE LIST HELPS TO ASSURE PATIENTS SAFETY AND AVOID DUPLICATION OF MEDICATION AND/OR DRUG INTERACTIONS. PLEASE SELECT ONE OF THE FOLLOWING AND SIGN BELOW.

_____ I GRANT CAROLINA MEDICAL CENTER PERMISSION TO ACCESS MY PRESCRIPTION HISTORY FROM EXTERNAL SOURCES.

_____ I DO NOT GRANT CAROLINA MEDICAL CENTER PERMISSION TO ACCESS MY PRESCRIPTION HISTORY FROM EXTERNAL SOURCES.

SIGNATURE OF PATIENT OR AUTHORIZED PERSON: _____
DATE:_____

Pain Management Agreement
Carolina Medical Center
Sanjay Kumar, M.D. and Michael Blubaugh, M.D.

The purpose of this Agreement is to prevent misunderstandings about certain medications you will be taking for pain management. This Agreement is to help you and your provider to comply with the New Law's regarding controlled pharmaceuticals.

I understand that there is a risk of psychological and/or physical dependence and addiction associated with chronic use of controlled substances.

I will not use any illegal controlled substances, including marijuana, cocaine, etc., nor will I misuse or self-prescribe/medicate with legal controlled substances.

I will not attempt to obtain any controlled medications, including opioid pain medications, controlled stimulants, or anti-anxiety medications from any other provider.

I agree that refills of my prescriptions for pain medications will be made only at the time of an office visit or during regular office hours. No refills will be available during evenings or on weekends.

I understand that my provider will be verifying that I am receiving controlled substances from only one prescriber and only one pharmacy by checking the Prescription Monitoring Program web site periodically throughout my treatment period.

I authorize the provider to cooperate fully with any city, state or federal law enforcement agency, including this state's Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my pain medication.

I agree that I will submit to a blood or urine test if requested by my provider to determine my compliance with my program of pain control medications before receiving prescriptions. .

I understand that if I break this Agreement, my provider will stop prescribing these pain control medicines.

All of my questions and concerns regarding treatment have been adequately answered

Date of Agreement _____ Patient Signature: _____

ACKNOWLEDGRMENT AND DESIGNATION OF DISCLOUSURE FORM

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER (CHECK ALL THAT APPLY)

HOME PHONE: _____

- ◯ WRITTEN COMMUNICATION
- ◯ OKAY TO LEAVE A MESSAGE WITH DETAILED INFORMATION
- ◯ OKAY TO MAIL TO MY HOME
- ◯ LEAVE A MESSAGE WITH CALL BACK NUMBER ONLY

CELL PHONE: _____

- ◯ OKAY TO LEAVE A MESSAGE WITH DETAILED INFORMATION
- ◯ LEAVE A MESSAGE WITH CALL BACK NUMBER ONLY

WORK PHONE: _____

- ◯ OKAY TO LEAVE A MESSAGE WITH DETAILED INFORMATION
- ◯ LEAVE A MESSAGE WITH CALL BACK NUMBER ONLY

DESIGNATION OF CERTAIN RELATIVE, CLOSE FRIENDS AND OTHER CAREGIVERS

I agree that Carolina Medical Center may disclose certain of my health information to a family member, close personal friend or other caregiver because such person is involved with my health care or payment relating to my health care. In that case, Carolina Medical Center will disclose only information that is directly relevant to the person's involvement with my heath care or payment relating to my health care. I designate the following persons listed below as persons involved with my healthcare or payment relating to my health care for the purpose of Carolina Medical Center to make the type of disclosures listed above (I understand that I am not required to list anyone and that I may change this list at anytime in writing.)

PRINT NAME/ RELATION/ TELEPHONE NUMBER

#:_____

PRINT NAME/ RELATION/ TELEPHONE NUMBER

#: _____

PRINT NAME/ RELATION/ TELEPHONE NUMBER

#: _____

_____ _____

SIGNATURE OF PATIENT/ PARENT/ GUARDIAN **DATE**

ACKNOWLEDGEMENT OF RECEIPT OF

NOTICE OF PRIVACY PRACTICE

FROM CAROLINA MEDICAL CENTER, WALTERBORO SC.

I, _____, HEREBY ACKNOWLEDGE THAT I RECEIVED A COPY OF THE CAROLINA MEDICAL CENTER NOTICE OF PRIVACY PRACTICES.

_____ _____

DATE SIGNATURE OF PATIENT OR PATIENT'S REPRESENTATIVE

_____

DESCRIPTION OF REPRESENTATIVE'S AUTHORITY

CAROLINA MEDICAL CENTER, WALTERBORO, SC

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

EFFECTIVE DATE SEPTEMBER 23, 2013

It is the intent of this Notice of Privacy Practices ("Notice") to inform individuals and patients of their privacy rights regurading uses and disclosures of their protected health information ("PHI") as required or permitted under applicable law, including the Health Insurance Portability and Accountability Act of 1996 ("HIPPA"). This Notice describes how protected health information may be used for treatment, payment, or other operations involved in obtaining treatmentfrom and providing payment to the Physician Practice ("Practice") for services rendered by its physicians. Protected health information is information about a patient that may be used to identify them, such as name, address, or social security number.

STATEMENTS OF USE AND DISCLOSURE:

***TREATMENT:** The practice will use PHI for the provision, coordination, and/or management of health care and related services. Those services could include, but are not limited to, the treatment of chronic and acute illnesses and the facilitation of specialized services.

***EXAMPLE:** Your physician will routinely use information about you for the treatment of an illness. That information may be used to prescribe medications through a pharmacy, or forwarded to another physician for additional consultations or treatment necessary for your health. Your PHI may be used in ordering laboratory or other diagnostic tests.

PAYMENT: The practice will use PHI where appropriate to facilitate payment for treatment or health care related services rendered by the Practice.

*EXAMPLE: When a Practice physician renders a service to you that is to be paid a health plan, a claim for that service must be created. The claim will contain information about you to include the type of treatment provided by you physicians with a diagnosis justifying the treatment. Depending on a diagnosis or treatment, the practice may request additional information about you before a payment for service is issued. If a specific test, procedure, or hospital stay is recommended for your treatment, the Practice plan may request additional information about you. Any disclosures

* **Operations:** The practice will use PHI as needed to maintain its operations.

* **EXAMPLE**