CARESOUTH CAROLINA INC.

HEALTH SERVICES ENROLLMENT FORM

Patient Information

FIRST NAME	LAST NAME	MIDDLE INITIAL

STREET ADDRESS	CITY	STATE	ZIP

SEX	SOCIAL SECURITY #	PRONOUN PREFERENCE	ETHNICITY	RACE (CHECK ALL THAT APPLY)
		☐ He ☐ She	☐ Hispanic ☐ Non-Hispanic	☐ Asian ☐ American Indian/Alaska Native ☐ Black/African American ☐ Hispanic ☐Native Hawaiian/Pacific Islander ☐ White/Caucasian ☐ Other/Unknown:_____

DATE OF BIRTH	EMAIL ADDRESS

PARENT/GUARDIAN INFORMATION (if patient under 18):			PERSON RESPONSIBLE FOR BILL	
NAME	RELATIONSHIP	DATE OF BIRTH	NAME	DATE OF BIRTH

TYPE	#1 PHONE NUMBER	TYPE	#2 PHONE NUMBER	PREFERRED METHOD OF CONTACT
☐Home ☐Work ☐Mobile		☐Home ☐Work ☐Mobile		☐ Letter ☐ Home Phone ☐ Cell Phone ☐ Work Phone

HOUSING		MIGRANT OR SEASONAL FARM WORKER	MARITAL STATUS	WHAT IS YOUR PRIMARY LANGUAGE?
Do you have a regular place to stay at night?	Do you live in public housing (Section 8)?			
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Single ☐ Divorced ☐ Widowed ☐ Married ☐ Other _____	

EMERGENCY CONTACT NAME	RELATIONSHIP	PHONE

MILITARY STATUS	Have you ever served in the military?	VOTER REGISTRATION: Would you like to register to vote?
☐ Current active military ☐ No prior military service	☐ Yes ☐ No	☐ Yes ☐ No ☐ Already registered

Sexual Orientation: ☐ Straight ☐ Lesbian, gay, or homosexual ☐ Bisexual ☐ Something else ☐ Do not know ☐ Choose not to disclose

Gender Identity: ☐ Male ☐Female ☐ Female-to-Male ☐ Male-to-Female ☐ Genderqueer ☐ Additional gender ☐ Choose not to disclose

In the past 2 years have you or a family member worked in agriculture (farm work)? ☐ Yes ☐ No

Have you or a member of your family stopped migrating for work in agriculture (farm work) because of a disability or old age? ☐ Yes ☐ No

In the past 2 years have you or a member of your family established a temporary home in order to work in agriculture (farm work)? ☐ Yes ☐ No

In the past 2 years have you or a member of your family work in agriculture (farm work) on a seasonal basis without the need to establish a temporary home? ☐ Yes ☐ No

Patient Insurance

PRIMARY INSURANCE COMPANY NAME	INSURANCE ID #	INSURANCE COMPANY PHONE #

SUBSCRIBER'S NAME	SUBSCRIBER'S ADDRESS	SUBSCRIBER'S DATE OF BIRTH

SECONDARY INSURANCE COMPANY NAME	INSURANCE ID #	INSURANCE COMPANY PHONE #

SUBSCRIBER'S NAME	SUBSCRIBER'S ADDRESS	SUBSCRIBER'S DATE OF BIRTH

☐ I do **not** have insurance ******If you are covered by any insurance, you are required to provide information above******

Monthly family income $ _____ | Number in household: _____ | **This may help determine eligibility for discounted services through a sliding scale fee.**

Authorization

By signing at the end of this document at the bottom of page 2:

- I hereby authorize CareSouth Carolina Inc. staff (and whomever they designate) to provide medical, telehealth, emergency and in-patient care of such treatment that may include/but is not limited to health screening, diagnosis, medical treatment social services, and/ or mental health and drug and alcohol screening, assessment, diagnosis and treatment as is found necessary. I also authorize the release of any medical information necessary to process claims and promote continuity of care with other healthcare and enabling services. I authorize payment to be made to CareSouth Carolina, Inc.
- I understand that my signature is also an **acknowledgement of receipt of CareSouth Carolina's notice of privacy practices**. By signing, I acknowledge that I have received and/or reviewed a copy of CareSouth Carolina's Notice of Privacy Practices.

(Continued on next page)

Patient Name:_____ Patient Date of Birth:_____

Authorization

By signing at the end of this document: (continued from previous page)

- I understand that my signature is also an **acknowledgement that I have received and reviewed CareSouth Carolina's guidelines regarding the E-prescribe program.** By signing, you are agreeing to enroll and allow CareSouth Carolina to request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes. However, I may choose to opt out of being enrolled in the E-prescribe program by checking the box below.
  ☐ I choose not to be enrolled in CareSouth Carolina's E-prescribe program.
- I am willing to make a commitment to my health. I choose CareSouth Carolina as my Health Care Home and will **be an active participant** in my health care: I will **speak up** when I do not understand, **share** accurate and complete information with my health care team, **educate myself** on my health and **get actively involved** in being healthy.

Confidential Communication and HIPAA Designation

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR (OR YOUR CHILD'S) MEDICAL CONDITION? IF YES, WHOM?

☐ No, I do not wish to authorize any person other than myself to obtain information regarding my (or my child's) protected health information. I am refusing. In the case of a minor child, no one other than me can bring my child to an appointment. (*Skip to the next section.)*

☐ Yes, I would like to designate another person to be able to be given information regarding my (or my child's) protected health information. In the case of a minor child, I give permission for CareSouth Carolina to provide medical treatment to my child when brought in for an appointment by the persons below. (If yes, *you must complete the box below)*

At my request, I authorize the person listed below to obtain information regarding my (or my child's) protected health information. In the case of a minor child, I authorize medical treatment given to my child when brought in by named person. Please initial beside the lines of how you want your protected health information disclosed. In the case of a minor child, at least the first line is required.

_____I give my permission to disclose and discuss information concerning my (or my child's) diagnosis, treatment, test results, medications and costs to the person named below.

_____ I give my permission to allow my (or my child's) records concerning my diagnosis, treatment, test results, medications and costs to be signed for and released to the person named below.

NAME		DOB	RELATIONSHIP	PHONE NUMBER
1.				
2.				

NOTE: This consent will be ongoing until you state in writing otherwise or until you fill out a new Confidential Communication/HIPAA Designation Form.

Pharmacy & Provider

CARESOUTH PROVIDER THAT I HAVE CHOSEN:_____

PHARMACY NAME: (please fill out section below)

Thank you for choosing CareSouth Carolina for your health care needs. Your prescriptions will be sent to CareSouth Community Pharmacy after your office visit.

Which CareSouth Location would you like to pick your prescription up? _____

☐ I would like to opt out and use _____ pharmacy in the town of _____.

Consent

By signing below, I consent to all the previous sections, unless otherwise noted as refused.

Patient/ Guardian Signature	Print name of patient/legal guardian	Relationship	Date
Witness	**Date**	**Reviewed by**	**Date:**
Sliding Fee Scale Information: _____%	**Category _____**	**Date _____**	