careSOUTH carolina

CARESOUTH CAROLINA INC.
HEALTH SERVICES ENROLLMENT FORM

Patient Information

FIRST NAME _____ **LAST NAME** _____ **MIDDLE INITIAL** _____

STREET ADDRESS _____ **CITY** _____ **STATE** _____ **ZIP** _____

EMAIL ADDRESS _____

SEX _____ **PRONOUN PREFERENCE** ☐ He ☐ She **SOCIAL SECURITY #** _____ **DATE OF BIRTH** _____

ETHNICITY ☐ Hispanic ☐ Non-Hispanic **RACE (CHECK ALL THAT APPLY)** ☐ Asian ☐ American Indian/Alaska Native ☐ Black/African American ☐ Hispanic ☐ Native Hawaiian/Pacific Islander ☐ White/Caucasian ☐ Other/Unknown

PARENT/GUARDIAN INFORMATION (if patient under 18)

Name _____ **Relationship** _____ **Date of Birth** _____

PERSON RESPONSIBLE FOR BILL NAME _____ **Date of Birth** _____

#1 PHONE NUMBER _____ **TYPE** ☐ Home ☐ Work ☐ Mobile **#2 PHONE NUMBER** _____ **TYPE** ☐ Home ☐ Work ☐ Mobile

PREFERRED METHOD OF CONTACT ☐ Letter ☐ Home Phone ☐ Cell Phone ☐ Work Phone

HOUSING Do you have a regular place to stay at night? ☐ Yes ☐ No **Do you live in public housing (Section 8)?** ☐ Yes ☐ No

MIGRANT OR SEASONAL FARM WORKER ☐ Yes ☐ No

MARITAL STATUS ☐ Single ☐ Divorced ☐ Widowed ☐ Married ☐ Other _____ **WHAT IS YOUR PRIMARY LANGUAGE?** _____

EMERGENCY CONTACT Name _____ **Relationship** _____ **Phone** _____

MILITARY STATUS ☐ Current active military ☐ No prior military service **Have you ever served in the military?** ☐ Yes ☐ No

VOTER REGISTRATION Would you like to register to vote? ☐ 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 yrs 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

Insurance Company Name _____ **Insurance ID #** _____ **Insurance Company Phone #** _____

Subscriber's Name _____ **Subscriber's Address** _____ **Subscriber's Date of Birth** _____

SECONDARY INSURANCE

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.

Patient Name: _____ Patient Date of Birth: _____

Authorization (continued from previous page)

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

- 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: _____

Thank you for choosing CareSouth Carolina for your health care needs. Your prescriptions will be sent to CareSouth Community Pharmacy after your office visit. At which CareSouth location would you like to pick up your prescription?

PHARMACY NAME: _____

☐ 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 _____ **Date** _____

Print name of patient/legal guardian _____ **Relationship** _____

Witness _____ **Date** _____

Reviewed by _____ **Date** _____ **Sliding Fee Scale Information:** _____ **% Category:** _____ **Date:** _____

BOTH PAGES MUST BE COMPLETED

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