Thank You For Choosing Spartanburg Regional Healthcare System For Your Healthcare Needs

Medical Group of the Carolina
A Division of Spartanburg Regional Healthcare System

Patient Registration Form
MGC - Magnolia Plastic Surgery

Please print or write legibly

PATIENT INFORMATION

Name: _____ Date of Birth: _____ Sex: M F

Mailing Address: _____ Marital Status: S M LS D W

City: _____State_____ Zip_____ Social Security#: _____

Street Address (if different from mailing) _____ Email address: _____

City: _____State_____ Zip_____ Primary Language_____

Race: [ ] White/Caucasian [ ] Black/African American [ ] Native Hawaiian [ ] AM Indian/Alaska Nat [ ] Asian/E Indian [ ] Unavailable/Unknown [ ] Declined to provide

Ethnicity: [ ] Hispanic/Latino [ ] Not Hispanic/Latino [ ] Declined

Phone: Home: _____ Cell: _____ Work: _____

Employer/School: _____Student: FT_____ PT_____ Primary Care Physician: _____

Is this visit for: Cosmetic Reconstructive Injury Other -- Please specify: _____

Email Address: _____ would you like to receive email specials from Magnolia Plastic Surgery: YES NO

Work Injury: Date of Injury: _____ Type of Injury _____

GUARANTOR INFORMATION (Person financially responsible for any patient balances)

[ ] **YOU may check here if the guarantor is the same as the patient**

Name: _____ Date of Birth: _____ Sex: M F

Mailing Address: _____ Social Security#: _____

City: _____State_____ Zip_____ Relationship to Patient: _____

Phone: Home: _____ Cell: _____ Work: _____ Preferred Phone: home cell work

Employer/School: _____email address: _____

EMERGENCY CONTACTS

THE PERSON OR PERSONS BELOW WILL BE CONTACTED IN THE EVENT OF AN EMERGENCY

Emergency Contact 1 _____ _____ _____
First Name Last Name Telephone

Emergency Contact 2_____ _____ _____
First Name Last Name Telephone

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PRIMARY INSURANCE INFORMATION (please provide copies of al medical insurance cards)

Name of Primary Insurance: _____ Certificate Number _____

Group Number _____ Co Pay Amount _____ Effective Date _____

SUBSCRIBER INFORMATION (*Person who carries the insurance*) [ ] *Check here if same as the patient*

Name: _____ DOB _____

Mailing Address: _____ Social Security#: _____

City: _____ State _____ Zip _____ Relationship to Patient: _____

Phone: Home: _____ Cell: _____ Work: _____

Employer/School: _____

SECONDARY INSURANCE INFORMATION (please provide copies of all medical insurance cards)

Name of Secondary Insurance: _____ Certificate Number _____

Group Number _____ Co Pay Amount _____ Effective Date _____

SUBSCRIBER INFORMATION (*Person who carries the insurance*) [ ] *Check here if same as the patient*

Name: _____ DOB _____

Mailing Address: _____ Social Security#: _____

City: _____ State _____ Zip _____ Relationship to Patient: _____

Phone: Home: _____ Cell: _____ Work: _____

Employer/School: _____

FINANCIAL POLICY

This information is to provide clarification for patients of Medical Group of the Carolinas regarding matters of insurance, co-pay, deductibles and co-insurance amounts due at the time of service. Physician Group Practices have an obligation to various Healthcare plans to apply any deductible and/or collect any co-payment prior to provision of services.

Co-Pays-You will be required to pay your co-payment upon arrival for your appointment

Deductibles and Co-Insurance-You will be asked at check in or check out for any deductible or co-insurance that may be applicable to your office visit

Previous Balances-You will be expected to provide payment for previous balances or balances sent to collections prior to your office visit. If you are unable to pay your balance in full, you may be asked to set up a payment plan. You may set up this plan with our office or contact Physicians Billing Service at 1-877-596-2455. Physicians billing service is Medical Group of the Carolinas billing service and will be glad to assist you with your questions about any billing inquiry

PLEASE SIGN THE ACKNOWLEDGMENT BELOW

I acknowledge that the above information is true and accurate demographic and insurance information for the patient listed on this registration form. I also acknowledge that by signing this form, I authorize payment of medical benefits to the undersigned physician or supplier for services described. I have also read the above Medical Group of the Carolinas financial policy and agree to the terms of the policy.

Patient Signature _____ Parent or Guardian Signature: _____

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Patient Name_____DOB:_____

PLEASE INDICATE YOUR PREFERRED METHOD OF CONTACT INFORMATION

How would you like to be contacted regarding appointments, treatment and/or other information pertinent to your healthcare and/or payment for your healthcare provided at the Medical Group of the Carolinas?

[ ] I may be contacted by "Any Method" If not "any method" please choose Restricted Contact Preferences

Restricted Contact Preferences [ ] Home Telephone [ ] Cell Phone [ ] Work Phone [ ] Mail [ ] E-Mail

May we leave a message on your answering machine/voicemail? [ ] Yes [ ] No

Of the selected preference or preferences above what is your preferred method of contact or how would you like to be contacted first?

[ ] Home Telephone [ ] Cell Phone [ ] Work Phone [ ] Mail [ ] E-Mail

HIPAA RELEASE OF INFORMATION

HIPAA DELEGATES

[ ] OPTION 1: THESE ELECTIONS WILL BE IN EFFECT FOR ALL MGC LOCATIONS

I authorize the person (s) listed below to receive all health information about appointments, treatment and/or other information pertinent to my healthcare and/or payment for my healthcare provided at the Medical Group of the Carolinas.

Name:_____Relationship:_____Phone:_____

Name: _____Relationship:_____Phone:_____

HIPAA DELEGATES

[ ] OPTION 2: THESE ELECTIONS WILL BE IN EFFECT FOR ALL MGC LOCATIONS

I do not authorize any information to be disclosed to any other parties except to me as the patient/guardian except in the event of an emergency. In an emergency you may contact the individuals listed below

Name: _____Relationship:_____Phone:_____

Name: _____Relationship:_____Phone:_____

Minor Patient Release

[ ] MINOR PATIENT RELEASE OPTION 3: THESE ELECTIONS WILL BE IN EFFECT FOR ALL MGC LOCATIONS

I authorize the following individual (s) to consent to medical treatment in my absence

Name: _____Relationship:_____Phone:_____

Name: _____Relationship:_____Phone:_____

PLEASE SIGN AND DATE BELOW

PATIENT/GUARDIAN SIGNATURE: _____DATE_____