HOPEWELL MEDICAL CARE LLC

2090 Woodruff Rd, Greenville SC 29607

Ph: (864) 729-8556 Fax: (864) 729-8558

PATIENT INFORMATION

DATE____________________

Patient____________________
Last First Middle

Address____________________
Street

____
City State Zip

Contact Phone____________________

Social Security No.____________________

Marital Status____________________

Email Address____________________

Date of Birth____________________

Employer____________________

____

Spouse's Name____________________

Spouse's Employer____________________

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RACE (circle one): American Indian or Alaska Native, Asian, Native Hawaiian, Black/African American, White/Caucasian, Hispanic, Other

Ethnicity (circle one):Hispanic or Latino, Not Hispanic or Latino, Refused to Report

Language (circle one): English, Indian (includes Hindi), Spanish, Russian, Other

Person Responsible for bill____________________

Address____________________ Home Phone____________________

____________________ Work Phone____________________

In Case of Emergency Contact:____________________ Phone____________________

Referring Physician's Name____________________

Primary Physician's Name____________________

Pharmacy____________________ Address____________________ Phone____________________

PRIMARY INSURANCE COVERAGE

Insured Name DOB____________________

ID#____________________ Group#____________________

Company____________________

Address____________________

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SECONDARY INSURANCE COVERAGE

Insured Name DOB____________________

ID#____________________ Group#____________________

Company____________________

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FOR MINOR CHILDREN, PLEASE COMPLETE THE FOLLOWING:

Father____________________

Address____________________

____

Phone No.____________________

Phone No.____________________

Father's Birthdate____________________ SS#:____________________

Employer____________________

____

Mother____________________

Address____________________

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Home Work

Mother's Birthdate____________________ SS#:____________________

Employer____________________

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Please fill this form out as completely as possible and bring this to your appointment

If you have filled out this form previously, please enter any changes in your health history that have occurred since your last visit.

Past Medical History (Please check any medical problems that you have had in the past)

- ☐Abnormal pap smear
- ☐Alcoholism
- ☐Allergies
- ☐Anemia
- ☐Anxiety
- ☐Arthritis
- ☐Asthma
- ☐Blood transfusion
- ☐BPH (benign prostatic hyperplasia)
- ☐Cancer
- ☐Cataracts
- ☐Clotting disorder
- ☐Colonic adenoma
- ☐Concussion
- ☐Congestive heart failure
- ☐COPD (lung disease)
- ☐Coronary artery disease
- ☐Depression
- ☐Diabetes mellitus
- ☐Diverticulitis
- ☐GERD (heartburn)
- ☐Glaucoma
- ☐Headaches
- ☐Heart murmur
- ☐HIV/AIDS
- ☐Hyperlipidemia (high cholesterol)
- ☐Hypertension (high blood pressure)
- ☐Hypothyroidism
- ☐Irregular menses
- ☐Kidney disease
- ☐Liver disease
- ☐Menorrhagia
- ☐Myocardial infarction (heart attack)
- ☐Nerve/muscle disease
- ☐Osteoporosis
- ☐Seizures
- ☐Sickle cell anemia
- ☐Sleep apnea
- ☐Stroke
- ☐Substance abuse
- ☐Tuberculosis
- ☐Ulcers
- ☐Other (list)

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Past Surgical History (Check any surgeries you have had and the date of surgery if you know it)

- ☐Appendectomy
- ☐Bariatric surgery
- ☐Brain surgery
- ☐Breast surgery
- ☐CABG (bypass)
- ☐Cesarean section
- ☐Cholecystectomy (gall bladder removal)
- ☐Colon surgery
- ☐Cosmetic surgery
- ☐Eye surgery
- ☐Fracture surgery
- ☐Hernia repair
- ☐Hysterectomy (ovaries removed)
- ☐Hysterectomy (ovaries remain)
- ☐Joint replacement
- ☐Other (list)
- ☐Prostate surgery
- ☐Small intestine surgery
- ☐Spine surgery
- ☐Tonsillectomy and Adenoidectomy
- ☐Tubal ligation (tubes tied)
- ☐Valve replacement
- ☐Vasectomy

Additional Information:

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Family History

Check below to report problems your family members have had. Please state the age when they had the problem if you know it. Please enter the name of the person in the blank.

☐Adopted (unknown/incomplete family history).

	Mother	Father	Sister	Brother	Daughter	Son	Other (list)
Alcohol abuse							
Aneurysm							
Asthma							
Autoimmune disease							
Birth defects							
Breast cancer							
Cancer							
Colon cancer							
Colon polyps							
COPD (lung disease)							
Deep vein thrombosis							
Dementia							
Depression							
Diabetes							
Heart disease							
High cholesterol							
Hypertension							
Kidney disease							
Mental illness							
Osteoporosis							
Prostate cancer							
Pulmonary embolism							
Stroke							
Thyroid disease							
Other (list)							
Other (list)							
Other (list)							
Alive (Yes, No or N/A=Not Applicable)							

Medications

Name of medication, indicate if pills, ointment, drops, etc.	Dose each time i.e. mg., drops, tsp., etc.	How many do you take at a time?	How often do you take this medication?	For what medical condition is this medication prescribed?

Allergies

Please list any allergies or adverse reactions you have had:

Medication or substance which caused the allergic reaction	What kind of reaction did you experience?	When did this reaction first occur?

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UCHENNA DIKE, M.D
2090 WOODRUFF ROAD
GREENVILLE, SC, 29607
PHONE: (864) 729-8556
FAX: (864) 729-8558

HIPAA Privacy and Release of Information Authorization

I, ________________________________ hereby authorize HOPEWELL MEDICAL CARE, LLC and its affiliates, its employees and agents, to use and disclose protected health information (e.g., information relating to the diagnosis, treatment, claims payment, and health care services provided or to be provided to me and which identifies my name, address, social security number, Member ID number) for the purpose of helping me to resolve claims and health benefit coverage issues.

I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws.

I understand that I have a right to revoke this authorization by providing written notice to. However, this authorization may not be revoked if, it's employees or agents have taken action on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment or payment for or coverage of services.

I have been advised of this practice's Privacy Practices, Release of Billing Information policy, Assignment of Benefits policy, and grant the practice Medication History Authority.

If applicable, Legal Representatives sign below:

By signing this form, I represent that I am the legal representative of the Member identified above and will provide written proof (e.g., Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the Member's behalf with respect to this authorization form.

____

Patient Printed Name   Date

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AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name	Date of Birth	Social Security Number

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with SC State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. HOPEWELL MEDICAL CARE, LLC uses Surescripts, Inc., a prescription system that allows prescriptions and related information to be exchanged between my providers and the pharmacy. The information sent between these systems may include details of any and all prescription drugs I am currently taking and/or have taken in the past. This information will be utilized to HOPEWELL MEDICAL CARE, LLC.
2. This authorization may include disclosure of prescription information related to alcohol and drug abuse, mental health treatment, and/or confidential HIV related information by Surescripts, Inc. to HOPEWELL MEDICAL CARE, LLC
3. I have the right to revoke this authorization at any time by writing to HOPEWELL MEDICAL CARE, LLC. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. Signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be re-disclosed by the recipient, and this re-disclosure may no longer be protected by state or federal law.
6. This authorization expires one year from the date of my signature below.
7. THIS AUTHORIZATION DOES NOT AUTHORIZE HOPEWELL MEDICAL CARE, LLC TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THOSE PERMITTED UNDER APPLICABLE LAW.

Signature of patient or representative authorized by law	Date
Relationship to Patient	Interpreter, if utilized
Witness Signature	

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Office Financial Policy Agreement

Thank you for choosing us as your primary care provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign the space provided. A copy will be provided to you upon request.

1. Insurance. We participate in most insurances' plans, including Medicare. If you are not insured by a plan, we do business with payment in full is expected at each visit. If you are insured by a plan, we do business with but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing you r insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. Co-payments and deductibles. All co-payments and deductibles must be paid at the time of services. This arrangement is part of your contract with your insurance company. Failure on our part to collect and co-payments and deductibles from patients can be considered fraud. Please help u sin upholding the law by paying your co-payment at each visit.

3. Non-covered services. Please be aware that some and perhaps all the services you receive may be non-covered or not considered reasonable or necessary by Medicare of other insurers. You must pay for theses services in full at eh time of visit.

4. Proof of insurance. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

5. Claims submission. We still submit your claims and assist you in any way we can reasonably help get you claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of you claim is your responsibility whether your insurance company pays your claim, your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

6. Coverage changes. I f your insurance changes, please notify before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your clam in 45 days, the benefits will automatically be billed to you.

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7. Nonpayment. If your account is over 90 days past due, you will receive a letter stating that you have 20-days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you, and your immediate family members may be discharged from the practice. If this is to occur, you will be notified by regular and certified mail that you have 30-days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

8. Missed appointments. Our policy is to change for missed appointments not canceled within a reasonable amount of time. Theses changers will be your responsibility and billed directly to you. Please hep us to serve you better by keeping your regularly scheduled appointment.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary changes for our area.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understood the payment policy and agree to abide by its guidelines:

____

Signature of patient or responsible party/ Date

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ACKNOWLEDGEMENT AND AUTHORIZATION:

- I have read and understand the HIPAA/Privacy Policy of HOPEWELL MEDICAL CARE LLC

  Signed____ Date: ____________________

- I hereby assign my insurance benefits to be paid directly to the healthcare provider

  Signed____ Date: ____________________

- I authorize HOPEWELL MEDICAL CARE LLC to release medical information required to process my claim

  Signed____ Date: ____________________

- I have read and understand the Financial Policy of HOPEWELL MEDICAL CARE LLC

  Signed____ Date: ____________________

- I authorize HOPEWELL MEDICAL CARE LLC to obtain/have access to my medication history

  Signed____ Date: ____________________

- I authorize my provider's office to contact me by mobile phone

  Signed____ Date: ____________________