



# HOPEWELL MEDICAL CARE LLC

2090 Woodruff Rd, Greenville, SC 29607  
Ph: (864) 729-8556 | Fax: (864) 729-8558

## PATIENT INFORMATION

Date: \_\_\_\_\_

Email Address: \_\_\_\_\_

Patient Name: \_\_\_\_\_  
Last First Middle

Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_  
Street

Employer: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_

Contact Phone: \_\_\_\_\_

Spouse's Employer: \_\_\_\_\_

Social Security No.: \_\_\_\_\_

Marital Status: \_\_\_\_\_

### Race (check one):

- American Indian or Alaska Native
- Asian
- Native Hawaiian
- Black/African American
- White/Caucasian
- Hispanic

### Ethnicity (check one):

- Hispanic or Latino
- Not Hispanic or Latino
- Refused to Report

### Language (check one):

- English
- Indian (Includes Hindi)
- Spanish
- Russian

Other: \_\_\_\_\_

## PERSON RESPONSIBLE FOR BILL

Name: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Referring Physician's Name: \_\_\_\_\_

Primary Physician's Name: \_\_\_\_\_

Pharmacy: \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_

### PRIMARY INSURANCE COVERAGE

Insured Name: \_\_\_\_\_ DOB: \_\_\_\_\_

ID#: \_\_\_\_\_ Group #: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Address: \_\_\_\_\_

### SECONDARY INSURANCE COVERAGE

Insured Name: \_\_\_\_\_ DOB: \_\_\_\_\_

ID#: \_\_\_\_\_ Group #: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Address: \_\_\_\_\_

## FOR MINOR CHILDREN, PLEASE COMPLETE THE FOLLOWING

Father's Name: \_\_\_\_\_

Mother's Name: \_\_\_\_\_

Phone No: \_\_\_\_\_

Phone No: \_\_\_\_\_

Work No: \_\_\_\_\_

Work No: \_\_\_\_\_

Address: \_\_\_\_\_

Address: \_\_\_\_\_

Birthdate: \_\_\_\_\_ (MM/DD/YYYY)

Birthdate: \_\_\_\_\_ (MM/DD/YYYY)

SSN: \_\_\_\_\_

SSN: \_\_\_\_\_

Employer: \_\_\_\_\_

Employer: \_\_\_\_\_

Employer Phone No: \_\_\_\_\_

Employer Phone No: \_\_\_\_\_

**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:

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Abnormal Pap Smear                 | <input type="checkbox"/> Congestive Heart Failure           | <input type="checkbox"/> Kidney Disease                       |
| <input type="checkbox"/> Alcoholism                         | <input type="checkbox"/> COPD (Lung Disease)                | <input type="checkbox"/> Menorrhagia                          |
| <input type="checkbox"/> Allergies                          | <input type="checkbox"/> Coronary Artery Disease            | <input type="checkbox"/> Myocardial Infarction (Heart Attack) |
| <input type="checkbox"/> Anemia                             | <input type="checkbox"/> Depression                         | <input type="checkbox"/> Nervous/Muscle Disease               |
| <input type="checkbox"/> Anxiety                            | <input type="checkbox"/> Diabetes Mellitus                  | <input type="checkbox"/> Osteoporosis                         |
| <input type="checkbox"/> Arthritis                          | <input type="checkbox"/> Diverticulitis                     | <input type="checkbox"/> Seizures                             |
| <input type="checkbox"/> Asthma                             | <input type="checkbox"/> GERD (Heartburn)                   | <input type="checkbox"/> Sickle Cell Anemia                   |
| <input type="checkbox"/> Blood Transfusion                  | <input type="checkbox"/> Glaucoma                           | <input type="checkbox"/> Sleep Apnea                          |
| <input type="checkbox"/> BPH (Benign Prostatic Hyperplasia) | <input type="checkbox"/> Headaches                          | <input type="checkbox"/> Stroke                               |
| <input type="checkbox"/> Cancer                             | <input type="checkbox"/> Heart Murmur                       | <input type="checkbox"/> Substance Abuse                      |
| <input type="checkbox"/> Cataracts                          | <input type="checkbox"/> HIV/AIDS                           | <input type="checkbox"/> Tuberculosis                         |
| <input type="checkbox"/> Clotting Disorder                  | <input type="checkbox"/> Hyperlipidemia (High Cholesterol)  | <input type="checkbox"/> Tumors                               |
| <input type="checkbox"/> Colonic Adenoma                    | <input type="checkbox"/> Hypertension (High Blood Pressure) |   |
| <input type="checkbox"/> Concussion                         | <input type="checkbox"/> Hypothyroidism                     |   |
| <input type="checkbox"/> Other (list) _____                 | <input type="checkbox"/> Irregular Menses                   |   |

### **PAST SURGICAL HISTORY**

Please check any surgeries you have had and list the date of surgery if known:

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Appendectomy                           | <input type="checkbox"/> Cosmetic Surgery               | <input type="checkbox"/> Prostate Surgery                |
| <input type="checkbox"/> Bariatric Surgery                      | <input type="checkbox"/> Eye Surgery                    | <input type="checkbox"/> Small Intestine Surgery         |
| <input type="checkbox"/> Brain Surgery                          | <input type="checkbox"/> Fracture Surgery               | <input type="checkbox"/> Spine Surgery                   |
| <input type="checkbox"/> Breast Surgery                         | <input type="checkbox"/> Hernia Repair                  | <input type="checkbox"/> Tonsillectomy and Adenoidectomy |
| <input type="checkbox"/> CABG (Bypass)                          | <input type="checkbox"/> Hysterectomy (Ovaries Removed) | <input type="checkbox"/> Tubal Ligation (Tubes Tied)     |
| <input type="checkbox"/> Cesarean Section                       | <input type="checkbox"/> Hysterectomy (Ovaries Remain)  | <input type="checkbox"/> Valve Replacement               |
| <input type="checkbox"/> Cholecystectomy (Gall Bladder Removal) | <input type="checkbox"/> Joint Replacement              | <input type="checkbox"/> Vasectomy                       |
| <input type="checkbox"/> Colon Surgery                          | <input type="checkbox"/> Other: _____                   |  |

**Additional information:**

---

---

---

## **FAMILY HISTORY**

Please check below to report problems your family members have had. State the age when they had the problem if known. Please enter the name of the person in the blank:

(Adopted patients should note "unknown" if incomplete family history)

<b><u>CONDITION</u></b>	<b><u>MOTHER</u></b>	<b><u>FATHER</u></b>	<b><u>SISTER</u></b>	<b><u>BROTHER</u></b>	<b><u>DAUGHTER</u></b>	<b><u>SON</u></b>	<b><u>OTHER</u></b>
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) -----							
<b>Alive (Yes, No or N/A=NotApplicable)</b> -----							

## **Medication**

<b>Name of medication, Indicate if pills, ointment, drops, etc.</b>	<b>Dosage each time, such as mg, drops, tsp, etc.</b>	<b>Name of medication, Indicate if pills, ointment, dorps, etc.</b>	<b>How often do you take this medication?</b>	<b>For what medical condition is this medication prescribed?</b>

## **Allergies**

***Please list any allergies or adverse reactions you have had:***

<b>Medication or substance which cause the allergic reaction</b>	<b>What kind of reaction did you experience?</b>	<b>When did this reaction first occur?</b>



# HOPEWELL MEDICAL CARE LLC

**UCHENNA DIKE, M.D**

2090 Woodruff Rd, Greenville, SC 29607

Ph: (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 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 the right to revoke this authorization by providing written notice. However, this authorization may not be revoked if its employees or agents have taken action on this authorization prior to receiving my written notice. I also understand that I have the 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: \_\_\_\_\_



# HOPEWELL MEDICAL CARE LLC

**UCHENNA DIKE, M.D**

2090 Woodruff Rd, Greenville, SC 29607

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

## 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:

- 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 by HOPEWELL MEDICAL CARE, LLC.
- 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.
- 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.
- 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.
- 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.
- This authorization expires one year from the date of my signature below.
- 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.

<b>Signature of patient or representative authorized by law:</b>	<b>Date:</b>
<b>Relationship to Patient:</b>	<b>Interpreter if utilized:</b>
<b>Witness Signature:</b>	



# HOPEWELL MEDICAL CARE LLC

**UCHENNA DIKE, M.D**

2090 Woodruff Rd, Greenville, SC 29607

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

## **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. To clarify patient and insurance responsibilities for services rendered, we have developed the following payment policy. Please read it carefully, 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 insurance 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 do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your 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 service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us uphold the law by paying your co-payment at each visit.

3. Non-covered Services: Please be aware that some, and perhaps all, of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of the 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 card 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 will submit your claims and assist you in any way we can to help get your 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 your claim is your responsibility whether your insurance company pays your claim or not. Your insurance benefit is a contract between you and your insurance company; we are not a party to that contract.



# HOPEWELL MEDICAL CARE LLC

**UCHENNA DIKE, M.D**

2090 Woodruff Rd, Greenville, SC 29607

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

6. Coverage Changes: If your insurance changes, please notify us 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 claim within 45 days, the balance will automatically be billed to you.

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 charge for missed appointments not canceled within a reasonable amount of time. These charges will be your responsibility and billed directly to you. Please help 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 charges 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: \_\_\_\_\_



# HOPEWELL MEDICAL CARE LLC

**UCHENNA DIKE, M.D**

2090 Woodruff Rd, Greenville, SC 29607

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

## ACKNOWLEDGEMENT AND AUTHORIZATION

- I have read and understand the HIPAA/Privacy Policy of HOPEWELL MEDICAL CARE LLC.
- I hereby assign my insurance benefits to be paid directly to the healthcare provider.
- I authorize HOPEWELL MEDICAL CARE LLC to release medical information required to process my claim.
- I have read and understand the Financial Policy of HOPEWELL MEDICAL CARE LLC.
- I authorize HOPEWELL MEDICAL CARE LLC to obtain/have access to my medication history.
- I authorize my provider's office to contact me by mobile phone.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

HOPEWELL MEDICAL CARE LLC  
KEEPING YOU WELL