

MUSC ORGANIZED HEALTHCARE ARRANGEMENT CAROLINA FAMILY CARE

Consent for Medical Treatment

I/we voluntarily consent to medical treatment and diagnostic procedures provided by Carolina Family Care and its associated physicians, clinicians and other personnel. I/we consent to the testing for infectious diseases, such as, but not limited to syphilis, AIDS, hepatitis and testing for drugs if deemed advisable by my physician. I/we am/are aware that the practice of medicine and surgery is not an exact science and I/we acknowledge that no guarantees have been made as to the result of treatments or examinations. I/we have read or have had read to me this consent and understand and agree to its contents.

Initials

Authorization for Release of Information and Assignment of Insurance Benefits

My physician is authorized to release any medical information required in the processing of applications or submission of information for financial coverage, including information referring to psychiatric care, drug and alcohol abuse, sexual assault, or tests for infectious diseases including AIDS/HIV for services provided during this admission. I/we also agree to the release of medical or other information about me to government regulatory agencies (federal or state) as required by law. For Medicare/Medicaid beneficiaries – I/we have provided all necessary information for proper assignment of Medicare/Medicaid benefits.

Initials

Agreement of Financial Responsibility

I/we guarantee payment of all charges associated with services received from Carolina Family Care (CFC) or other related medical organizations, including University Medical Associates (UMA), Medical University Hospital Authority (MUHA), or any other related organization on behalf of the named patient. I/we agree to assign any insurance benefits or other funding to Carolina Family Care. I understand it is my responsibility to verify participation status of the physician with my health plan prior to the patient's visit and to obtain all authorization as required by my health plan prior to the patient's visit.

Initials

H.I.P.A.A. (Health Insurance Portability and Accountability Act) Notification:

I acknowledge my receipt of a copy of the MUSC Organized Health Care Arrangements Notice of Privacy Practices.

Initials

Agreement of Financial Responsibility for Non-Covered Services (Not applicable for all patients)

By signing and dating this form, I am indicating that I have been informed by Carolina Family Care or other related organization that the services the patient will receive today may not be covered because of the reason indicated below.

(Patient to Initial the appropriate section if applicable.)

_____ CFC/the rendering physician is not a contracted/credentialed provider for your health plan. You will be responsible for any amounts not covered by your insurance plan.

_____ Your insurance carrier/primary care physician has not provided a referral/authorization for today's service. You will be responsible for any amounts not covered by your insurance plan.

_____ Your condition may be considered pre-existing based on the length of your coverage under your insurance plan. You may be responsible for the entire cost of the service.

_____ Your service may not be considered medically necessary by your insurance plan. You may be responsible for the entire cost of the service.

_____ Other reason: _____

I understand that the consent for medical treatment, authorization for release of information, assignment of insurance benefits, and agreement of financial responsibility will be valid for one year from the date of signature and can only be revoked upon written notice. By signing below, I/we acknowledge that this consent form has been read in full and explained as necessary.

Date and Time

Signature of Patient (Parent or Legal Guardian)

Signature of Witness

Signature of Guarantor (if different from the patient)



James Island Internal
650 Ellis Oaks Avenue
Charleston, SC 29412
(843) 762-5480
Fax (843) 762-5488

Edward Gilbreth, MD
Kathy Bolus, MD

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

Medical Record Number: _____ Social Security Number: _____

I authorize MUSC Medical Center and/or Charleston Memorial Hospital to disclose/release information on the above named individual.

The type of information to be disclosed is as follows:

- checkbox problem list, medication list, laboratory results, physician progress note / visit notes, consultation reports
checkbox list of allergies, immunization record, radiology reports, nurses notes, entire record
checkbox history and physical, discharge summary, films / images, physician orders, other

For dates of service: _____

I understand this information may include reference to (check all that apply):

- checkbox psychiatric / psychological care, checkbox durg abuse and /or
checkbox sexual assault, checkbox results of tests for all infectious diseases including HIV/AIDS.
checkbox alcohol abuse and / or

I authorize the disclosure of this information via (check preferred method):

- checkbox mail checkbox fax checkbox e-mail checkbox other _____

The information is to be checkbox disclosed to / checkbox obtain from: Name of individual / organization:

Street address: _____ City: _____ State: _____ Zip code _____

Phone number: _____ Fax number: _____ E-mail address: _____

The purpose of the disclosure is: _____

I understand that I have a right to cancel / revoke this authorization at any time. I understand that if I cancel / revoke this authorization I must do so in writing and present my written cancellation / revocation to the Health Information Services Department (Medical Records). I understand that the cancellation / revocation will not apply to information, which has already been released in response to this authorization as stated in the Notice of Privacy Practice. Unless otherwise canceled / revoked this authorization will expire / end 90 days from this date.

I understand that a reasonable, cost-based fee for copies of protected health information and postage fees will be charged.

I understand that authorizing the disclosure of protected health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to receive treatment. I understand I may review and / or copy the information to be disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the possibility on unauthorized disclosure by the person / organization receiving the information. If I have questions about the disclosure or use of my protected health information I may contact the MUSC Patient and Family Liaison. The number is (843) 792-5555.

I understand I will be given a copy of this authorization.

I understand that if this information is requested in person I will be asked to provide picture identification (e.g. driver's license). A copy of my identification will be made and attached to this authorization.

Signature of Patient or Legal Guardian / Representative _____

Date _____

Printed Name of Patient or Leagal Guardian / Representative _____

Relationship to Patient, if signed by legal guardian / Representative _____

Witness Signature _____

Description of Patient representative's authority: _____

(Why patient not signing)

To contact Health Information Service (Medical Records) in writing the address is 169 Ashley Avenue / PO Box 250349 / Attention: Release of Information / Charleston, South Carolina 29425; the phone number is (843) 792-3881

CAROLINA FAMILY CARE
Patient Information Sheet

Last Name	First	MI	Marital Status	Sex	DOB
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Address	City	State	Zip Code
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Home Phone #	Cell Phone #	Social Security #
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Employer Name	Employer Address	Work Phone #
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GUARANTOR INFORMATION:

Last Name	First	MI	Relationship	DOB	Home Phone #
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Address	City	State	Zip Code
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PRIMARY INSURANCE INFORMATION:

Subscriber's Name	Relation to Patient	Home Phone #	DOB
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Insurance Company Name	Policy #	Group #
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Insurance Company Address	City	State	Zip Code
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Insurance Company Phone #	Effective Date
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SECONDARY INSURANCE INFORMATION:

Subscriber's Name	Relation to Patient	Home Phone #	DOB
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Insurance Company Name	Policy #	Group #
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Insurance Company Address	City	State	Zip Code
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Insurance Company Phone #	Effective Date
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IN CASE OF EMERGENCY, CONTACT:

Name	Relationship	Phone#
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Patient Signature (Parent/Guardian, in case of minor)	Date
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CAROLINA FAMILY CARE

James Island Internal Medicine
650 Ellis Oaks Avenue
Charleston, SC 29412

PH (843) 762-5480
Fax (843) 762-5488

Edward M. Gilbreth, M.D., F.C.C.P.
Kathy Siegfried Bolus, M.D.

Patients Name: _____ DOB: _____ / _____ / _____

Explanation of Preventive Exam

The definition of a preventive exam is a yearly physical not related to any injury, specific/chronic illness or a diagnostic screening exam. This may include breast, pap smear, rectal or prostate exam and any labs. Usually, most insurance companies do not cover any of the above unless it is specifically stated in your contract. Due to the various insurance contracts we are unable to verify this information for you. You should contact your insurance company prior to having a preventive exam if you are unsure.

I have read the above and understand that my physician will be billing the services rendered today (including any additional test and labs) as a preventive exam.

Signature of Patient

Date

Signature of Witness

Date

MUSC

CAROLINA FAMILY CARE

Edward M. Gilbreth, M.D., F. C.C.P.
Kathy Siegfried Bolus, M.D.

James Island Internal Medicine
650 Ellis Oaks Avenue
James Island, SC 29412

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Fax (843) 762-5488

PERSONAL RELEASE OF INFORMATION

I, _____, do hereby authorize a representative from CFC James Island Internal Medicine to speak with the following persons(s) regarding my: (please check all that apply)

Name	Relationship	Phone Number	Medical Care	Financial	Appointments
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Do you give the above representative authorization to the following information:

I do I do **NOT** authorize release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency) Infection, sexually transmitted diseases, psychiatric care, psychological assessment and treatment for alcohol and/or drug abuse.

I do **NOT** wish for any medical information/appointments be released to any representative on my behalf.

(Signature of Patient)

(Date)

(Witness)

(Date)

This form will be valid until patient rescinds authorization in writing.