Phone: 864-656-3076 **Fax: 864-656-1123**

CLEMSON RURAL HEALTH

CONSENT FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

You have voluntarily presented yourself to Clemson University - Clemson Rural Health to receive health services. In order to provide the services you've requested, we must routinely collect, use and disclose personal health information about you such as name, address, marital status, age, and other individually identifiable health information in order to treat you, bill for treatment, and/or to carry out the routine operations of CRH such as administrative, financial, legal, and quality improvement activities. We respect your need for privacy and confidentiality and we have significant safeguards to prevent misuse of your private information.

Please read this consent carefully. If you have questions or concerns about this consent, please ask to speak with CRH's Administrative Coordinator or Director.

PERMISSION TO USE AND DISCLOSE HEALTH INFORMATION: By signing this form, you give CRH permission to use and/or disclose your personal health information in order to carry out treatment, payment, or health care operations.

Treatment: We will use and disclose your personal health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your protected health information. We will also disclose personal health information to other health care providers who may be treating you when we have the necessary permission from you.
For example, information about you may be provided to a health care provider to whom you have been referred to ensure that the provider has the necessary information to diagnose or treat you. In addition, we may disclose information about you from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of the health care provider in CRH, becomes involved in your care by providing assistance with your health care diagnosis or treatment.

Payment: We must use your personal health information, as needed, to obtain payment for your health care services.

For example, some of our services are paid for in full or in part through grants or contracts. We may submit information about you to the grantor, contractor, or insurer in order to obtain payment.

Health Care Operations: We must use or disclose, as needed, your personal health information in order to support the operations of CRH. CRH is an academic nursing center and we support the mission (teaching, research, and service) of Clemson University. Students and faculty are an integral part of our daily operations. Health students, trainees, or practitioners in areas of health care learn under supervision to practice or improve their skills as health care providers and they will have access to your personal health information as part of their training. Routine activities include, but are not limited to program evaluation, quality improvement activities such as client satisfaction surveys, employee review activities, training of health professions students, licensing activities, and conducting or arranging for other business activities.

For example, in order to evaluate our programs and services, we collect information about the number of clients we've treated, types of services, treatment outcomes, client satisfaction, etc. We review this information regularly in order to continuously improve our services. We report summary information to grantors or contractors who are providing support for our programs. For example, we provide information about the number of women who have received clinical breast exams and mammograms and the number of the exams that were normal or abnormal. In addition, our faculty members are often invited to speak at professional conferences and to present summary information about our programs and services. We do not reveal your personal identity nor is it linked to any of the summary data reported. *This is considered by Clemson's Office of Research Compliance (ORC) to be program evaluation or health services research. If you sign the consent form, you will be participating in this health services research. If you have any questions or concerns about our program evaluation or health services research, please feel free to talk with our Director, at 656-3076.*

RIGHT TO REQUEST RESTRICTIONS ON USE/DISCLOSURE: You have the right to request a restriction as to how your personal health information is used or disclosed to carry out treatment, payment, or health care operations of CRH;

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however, CRH is not required to agree to the restrictions if the restrictions might limit our ability to treat, receive payment for services, or carry out the operations of CRH. For example, you may request to receive confidential communications from us at a different address or in a different way, such as calling you at your office instead of at your home. You may request a restriction by filling out a form. Ask a Service Coordinator for the form.

RIGHT TO REFUSE: You have the right to refuse to sign this consent; however, we cannot provide you with services, except for emergency care, without your signature.

RIGHT TO REVIEW THE NOTICE OF PRIVACY PRACTICES: Your signature below acknowledges that you have received a copy of CRH's Notice of Privacy Practices. You have the right to review this notice before signing this consent. The Notice of Privacy Practices describes the types of uses and disclosures of your personal health information that will occur in your treatment, payment of your bills or in the performance of health care operations of CRH. The Notice of Privacy Practices for CRH is also displayed on CRH's website at http://www.clemson.edu/centers-institutes/sullivan/Privacy/. This Notice of Privacy Practices also describes your rights and CRH's duties with respect to your personal health information.

CHANGES TO THE NOTICE OF PRIVACY PRACTICES: CRH may change the Notice of Privacy Practices as needed. You may obtain a current copy of CRH's Notice of Privacy Practices by contacting a Service Coordinator at 864.656.3076 or by going to CRH's website at http://www.clemson.edu/centers-institutes/sullivan/Privacy/.

RIGHT TO WITHDRAW THIS CONSENT: You have the right to withdraw this consent at any time except to the extent that CRH has already taken action in reliance on this consent. You must withdraw this consent in writing. If you withdraw this consent, CRH cannot provide you with further treatment or follow-up other than required emergency services.

EFFECTIVE PERIOD: This consent is good unless and until you withdraw it in writing.

If you are signing this consent on behalf of another person, it is because you are the legal guardian, parent, or agent under an active Power of Attorney for Health Care, and you must be legally authorized to sign this Consent on behalf of the individual.

_____
Signature of Patient or Personal Representative

_____
Print Name of Patient or Personal Representative

_____
Description of Personal Representative's Authority

_____
Date

NOTE: The terms "protected health information," "personal health information," and "identifiable personal information" have the same meaning and may be used interchangeably.

Effective January 31, 2003
Revised 07/12/2012; 07/01/2021

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CLEMSON RURAL HEALTH

Our Financial Policy

Dear Patient,

Welcome and thank you for choosing our practice. We believe that establishing a written financial policy is mutually beneficial for all parties.

We participate with several insurance plans. However, each insurance plan has different benefits as well as different financial obligations. Therefore you, as the patient, are responsible for verifying these benefits with your insurance company. We will file your insurance, as a courtesy to you, but you are responsible for any unpaid balance which may include co-pays, coinsurance, and/or deductibles.

The following are the conditions for services provided to the patient by Clemson University's Clemson Rural Health and the various entities and providers associated with CRH.

Please read this financial policy carefully. If you have any questions about this policy, any member of our staff will be glad to assist you.

- Payment for Service: Our office will inform you of co-pay and deductible amounts at check in or check out. These amounts are due at the time of service. As a courtesy to you, we will file your insurance claims for those insurance companies for which we are a provider, if you provide us with a copy of your current insurance card. We require that you pay your deductible, co-payment, and/or any charges not covered by insurance. Payment is required at the time of service. This may include your co-pay, co-insurance, deductible and any other unpaid balances.
- Method of Payment: You may pay your bill with cash, personal check, certain credit cards, or debit card.
- Returned Checks: A service charge will be added on all checks returned to us for insufficient funds.
- Non-appointment Prescription Refills: A $10.00 charge per incidence may be added for non-appointment prescription refills.
- Completion of Medical Forms: There may be a charge for completion of forms such as disability, camp physicals, etc.
- Copies of Medical Records: There may be a charge for completion of this process; SC Sec. 44-7-325 for Health Care Facilities:
    - $0.65 per page for first 30 pages
    - $0.50 per page for all other pages
    - Clerical fee not to exceed $25.00
    - Plus actual postage
- Payment for Services Provided by Certain Providers: If you are having laboratory and/or diagnostic services by providers other than this office or other practices, you may be billed separately by that service provider. This includes services provided by laboratories.
- Questions: We are here to help you should you have any questions regarding your statement or insurance.

We appreciate the opportunity to be involved in your healthcare. If you have any questions regarding your account or need to make payment arragngements, please contact our business office at 864-656-3076. We are open Monday through Friday, 8:00 AM – 4:30 PM.

I have read, understand and agree to the above financial policy. I acknowledge full responsibility for services rendered and agree to make definite financial arrangements for payment. I understand that the charges may not be covered in full by my health insurance, and therefore I am solely responsible for payment of all uncovered services.

_____ _____

Patient Signature Date Signed

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CLEMSON RURAL HEALTH

AUTHORIZATION FOR DISCLOSURE OF MEDICAL INFORMATION

THE INFORMATION PROVIDED IN THIS FORM WILL BE RELIED UPON BY ALL HEALTH CARE PROVIDERS OF CLEMSON UNIVERSITY – CLEMSON RURAL HEALTH UNLESS REVOKED OR MOMDIFIED BY THE PATIENT IN WRITING.	**(FOR OFFICE USE ONLY)** MRN _____
Patient Name (PRINT)	**DOB**

Authorization for Disclosure of Medical Information: The privacy of your medical information is important. We will discuss your medical condition with person(s) you designate.

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHOM? (Check and complete one)

☐ The following family members or other individuals may receive information regarding my medical condition:
Print first and last name(s) _____

_____

OR

☐ Any family member or other individual inquiring about my medical condition may receive information from my provider, EXCEPT the following individuals:
Print first and last names(s)_____

_____

You may revoke/cancel or modify/change the above designation, but the revocation or modification must be in writing.

NOTE: This designation does not give the above named individuals the right to make healthcare decisions for you. If at any time you are unable to consent to care or treatment, we will follow the procedure set forth in the South Carolina Adult Health Care Consent Act.

Confidential Communication: Please provide phone number(s) where we can reach you:

☐ Home: _____ ☐ Work: _____ ☐ Cell Phone: _____ ☐ Other: _____

Messages: A request for return calls may be left on the following answering machines or voice mail: (Check all that apply)

☐ Home ☐ Work ☐ Cell Phone ☐ Other

I authorize my medical information to be left on the following answering machine or voice mail: (Check all that apply)

☐ Home ☐ Work ☐ Cell Phone ☐ Other

If we are unable to reach you or leave a message at the above phone number(s), please indicate with whom we may leave a message for you to call our facility.

Name: _____ Phone Number: _____
Name: _____ Phone Number: _____

Note: An automated appointment reminder system may call the number listed in our database.

Emergency Contact Information: In the event of an emergency, please contact the following individual(s):
Name (please print): _____ Phone Number: _____
Relationship: _____ Does this person need an interpreter? ☐ Yes ☐ No
Name (please print): _____ Phone Number: _____
Relationship: _____ Does this person need an interpreter? ☐ Yes ☐ No

Signature: I hereby authorize the disclosure of my medical condition and information as described above.

Patient/Patient's Representative Signature: _____ Date: _____ Time: _____

PRINT Name (If Patient's Representative): _____

Relationship to Patient (If Patient's Representative): _____

CRH Representative: _____ Date: _____ Time: _____

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CLEMSON RURAL HEALTH

NEW PATIENT FORMS

All questions contained in this document are strictly confidential and will become part of your medical record. Please fill in as much of the information as possible so that we may maintain accurate records.

PATIENT INFORMATION (PLEASE PRINT)			TODAY'S DATE:
Name *(Last, First, M.I.):*			
Sex: ☐ Male ☐ Female ☐ Unknown		**Date of Birth:**	**Preferred Name or Alias:**
Home address:			**Contact Information:**
City:			**Home Phone:**
State:	**Zip:**		**Work Phone:**
County:	**Country:**		**Mobile Phone:**
			Email:

General Information			
Marital status:	☐ Single ☐ Married ☐ Legally Separated ☐ Divorced ☐ Significant other ☐ Widowed ☐ Unknown		
Veteran Status:	☐ Non Veteran ☐ Active Duty ☐ Guard/Reserves ☐ Veteran		
Written Language:		**Ethnicity**	☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown
Needs Interpreter?	☐ Yes ☐ No	**Preferred Language**	

Race
☐Caucasian (White) ☐American Indian or Alaska Native ☐African American (Black) ☐Native Hawaiian or Other Pacific Islander ☐Other ☐Unknown

Education Level: ☐ Elementary ☐ High school ☐ Vocational ☐ College ☐ Graduate/professional

Employment Status: ☐ Full Time ☐ Part Time ☐ Student Full Time ☐ Student Part Time ☐ Self Employed ☐ Active Military ☐ Retired Date _____ ☐ Disabled ☐ Not Employed ☐ Unknown

Are you employed at Clemson University? ☐ Y ☐ N	**If yes, which department?**	
Occupation:	**Employer:**	
Previous or referring healthcare provider:	**Date of last physical exam:**	

PHARMACY INFORMATION		
Local Pharmacy:	**Contact phone number:**	
Mail Order Pharmacy:	**Contact phone number:**	

INSURANCE INFORMATION (Please give your insurance card to the receptionist)

MARK HERE IF YOU DO NOT HAVE INSURANCE OR WOULD LIKE TO SELF PAY ☐

Parent/guardian presenting a minor child for treatment will be listed as guarantor. If 18 or older, patient will be listed as guarantor and does not have to complete this action. The guarantor will be responsible for any balance due.

Name (Last, First, M.I.):	**Patient relation to Guarantor:**
Subscriber's Name on card:	**Patient relationship to Subscriber:**
Subscriber's Date of Birth:	**Sex**: ☐ Male ☐ Female ☐ Unknown
Home address:	**City:** **State:** **Zip Code:**
Insurance Co Name:	
Policy #:	**Group Number:**

IMMUNIZATION REQUEST

Please select below the immunizations you would like to receive during the scheduled clinic at your location:

☐ Influenza (flu)

☐ MMR (Measles, mumps, rubella)

Authorization:

I authorize medical evaluation and treatment, and release of information for medical/insurance purposes concerning my illness and treatment. I hereby authorize payment from my insurance company to Clemson University – Clemson Rural Health for services rendered. I will be responsible for any amount not covered by my insurance.

Signature of Patient/Guardian/Guarantor: _____ **Date:** _____

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