ReGenesis Health Care

My Family. My Doctor. My Choice.

Phone: (864) 582 – 2411 | Fax: (864) 582 – 7178
P.O. Box 5158 | Spartanburg, SC 29304
www.myrhc.org

Patient Information:

Patient Name: _____
Last Name *First Name* *Middle Name*

If a Minor: _____ _____ _____ _____
Mother's Name/Legal Guardian *Relationship* *Father's Name/Legal Guardian* *Relationship*

Date of Birth: _____ Age: _____ Social Security Number (optional): _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Cell Phone: _____ Home Phone: _____ Other: _____

Email: _____

Emergency Contact: _____ Phone: _____ Relationship to Patient: _____

Pharmacy:

ReGenesis Health Care offers an in-house pharmacy with **reduced pricing and FREE medications** as well as delivery and drive-through services available at certain locations. If you want your prescription(s) filled at a ReGenesis Family Pharmacy location, please choose which location you would like as your preferred pharmacy.

Langdon **Spartanburg** **Gaffney** **Duncan** **Woodruff**

If not, please list your preferred pharmacy name, location and phone number:

_____

Do you have an Advance Directive?

☐ Yes

☐ No

If yes, please provide a copy to your healthcare provider for your medical chart.

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Patient Demographics:

Gender at Birth:

☐ Male

☐ Female

Preferred Pronouns: _____

Sexual Orientation:

☐ Straight or Heterosexual

☐ Lesbian/Gay or Homosexual

☐ Bisexual

☐ Do Not Know

☐ Decline to Specify

☐ Other: _____

Gender Identity:

☐ Male

☐ Female

☐ Female-to-Male (FTM)/Transgender Male/Trans Man

☐ Male-to-Female (MTF)/Transgender Female/Trans Woman

☐ Genderqueer, Neither Exclusively Male nor Female

☐ Decline to Specify

☐ Other: _____

Marital Status:

☐ Single

☐ Married

☐ Divorced

☐ Widowed

☐ Separated

☐ Life Partner

☐ Legally Separated

☐ Unknown

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Language:

☐ English

☐ Spanish

☐ Russian

☐ Chinese

☐ French

☐ German

☐ Italian

☐ Japanese

☐ Sign Language

☐ Other (please specify): _____

Translator Needed:

☐ Yes

☐ No

Do you need vision assistance?

☐ Yes

☐ No

Do you need hearing assistance?

☐ Yes

☐ No

Do you need cognitive assistance?

☐ Yes

☐ No

Do you need mobility assistance?

☐ Yes

☐ No

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Race (check all that apply):

☐ Caucasian/White

☐ African American/Black

☐ American Indian/Alaska Native

☐ Asian Indian

☐ Chinese

☐ Filipino

☐ Japanese

☐ Korean

☐ Vietnamese

☐ Other Asian

☐ Native Hawaiian

☐ Samoan

☐ Guamanian/Chamorro

☐ Other Pacific Islander

☐ More than One Race

☐ Decline to Specify

☐ Other (please specify): _____

Ethnicity:

☐ Mexican/Mexican American/Chicano

☐ Puerto Rican

☐ Cuban

☐ Another Hispanic/Latino/Spanish Origin

☐ Hispanic/Latino

☐ Non-Hispanic/Non-Latino

☐ Decline to Specify

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Are you homeless?

☐ Yes

☐ No

If yes, check all that apply:

☐ Doubling Up

☐ Shelter

☐ Street

☐ Transitional

☐ Unknown

☐ Other (please specify): _____

Are you in need of housing assistance?

☐ Yes

☐ No

Are you an Agricultural Farm Worker?

☐ Seasonal Worker

☐ Agricultural Worker

☐ Dependent of Ag Worker

☐ Dependent of Seasonal Ag Worker

☐ Not an Agricultural Worker

Are you a Veteran?

☐ Yes

☐ No

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Insurance Information (please provide copies of all medical insurance cards):

Co-payments are required at time of visit and/or payment for services not covered by insurance.

Insurance Type:
□ Private Insurance
□ Self Pay
□ Workers Comp
□ Disabled
□ Other: _____

Plan Name:
Primary Insurance: _____ Certificate/Plan Number: _____ Effective Date: _____

Plan Name:
Other Insurance: _____ Certificate/Plan Number: _____ Effective Date: _____

Guarantor Information (person financially responsible for any patient balance): □ Check if same as the Patient

Name: _____ Date of Birth: _____

Relationship to Patient: _____ Social Security Number (optional): _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Best way to reach you?
□ Home
□ Cell

Subscriber Information (person who carries the insurance): □ Check if same as the Patient

Patient Name: _____ Date of Birth: _____

Relationship to Patient: _____ Social Security Number (optional): _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Best way to reach you?
□ Home
□ Cell

No Show Policy

Patients who are not able to make their scheduled appointments are requested to call RHC at least 24 hours in advance to cancel and reschedule their appointment. Patients who fail to properly cancel their appointments within 24 hours will be considered a no show. The first time a patient does not properly cancel their appointment it will be documented in their patient chart. The second time a patient does not properly cancel their appointment it will be documented in their patient chart and their account will be assessed a $25 cancellation fee on their account. The third time a patient fails to properly cancel their appointment, the patient may be assessed an additional cancellation fee on their account and will only be allowed to utilize same day appointments for 6 months.

I authorize the release of any required medical information from my record to the above insurance company to process my claim. I understand that I am responsible for any charges not covered by insurance or other forms of benefits.

_____

Printed Patient Name

_____ _____

Signature of Patient/Guardian **Date**

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Consent for HIPAA Release Form:

To protect your privacy, we ask that you complete this form so we know how we may communicate with you regarding your health information. Please mark as many of the communication options below as you feel comfortable with, so we have multiple ways to reach you regarding important matters concerning your health care.

Patient Full Name: _____ Date of Birth: _____ Last 4 of SS# (optional): _____

I prefer to receive my appointment reminders and information in the following method:

☐ Text Message

☐ Phone Call

☐ Healow Patient Portal

☐ Email

☐ Written Documentation

I authorize ReGenesis Health Care to discuss my healthcare as indicated with the following individuals:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

The following items can be shared and/or discussed:

Appointment Reminders:	Test Results:	Billing Information:
☐ Yes	☐ Yes	☐ Yes
☐ No	☐ No	☐ No

If applicable, your children's immunization records and/or school excuses may be released as needed to the following schools and/or daycares:

Name: _____ Phone: _____

I hereby release ReGenesis Health Care, its officers, agents, and employees from all liabilities, damages, and claims which might arise from the release of information authorized above. I understand that signing this form is voluntary, and I acknowledge that this consent relates to protected information and is valid for **one year** from signature unless otherwise stated above.

_____

Printed Patient Name

_____ _____

Signature of Patient/Guardian **Date**

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Patient Financial Responsibility Summary

Thank you for choosing ReGenesis Health Care as your primary care provider. We are committed to providing patient-centered, affordable, and accessible healthcare to all individuals, regardless of their ability to pay. The following summarizes options to ensure that no patient will be denied services due to inability to pay.

Payment for Services

- Fees for services rendered, including co-payments, deductibles, and any outstanding balances are due at the time of service.
- Patients experiencing financial hardship may request alternative payment arrangements or financial assistance programs. Our registration staff are available to discuss available options.

Sliding Fee Scale Discount Program

- Eligible ReGenesis patients can receive discounted services based on household income and family size, regardless of insurance status.
- Patients must provide income and household information as requested to verify eligibility.
- Eligibility for the sliding fee discount program is evaluated annually or as circumstances change.

Insurance

- We participate in and bill most insurance plans, including Medicaid and Medicare.
- Patients are responsible for providing accurate insurance information at each visit to ensure timely and accurate billing.
- Any services not covered by insurance, including co-payments, deductibles, or non-covered services, are the patient's responsibility.

Collections and Financial Assistance

- Patients with outstanding balances will receive billing statements.
- We are committed to working with patients to establish reasonable payment arrangements.

Non-covered Services

- Please be aware that some of the services, treatments, and/or supplies received during the visit may not be covered by your insurance. In this event, the patient is responsible for the balance due.
- Alternative payment arrangements or financial assistance programs are available for those experiencing financial hardships.

The undersigned hereby acknowledge to have read and agree with the above payment policy of ReGenesis Health Care. Thank you for trusting us with your health.

_____

Printed Patient Name

_____ _____

Signature of Patient/Guardian **Date**

Relationship to patient if signed by someone other than the patient: _____

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Packet Checklist:

1. Photo ID, Passport, or Any Form of Government-Issued ID (US or Out-of-County)
   If you do not have a Photo ID/Passport, you will be required to present your Social Security Card.

2. Social Security Card (optional)

3. Insurance Card (Medicare, Medicaid, BCBS, etc.)

4. Immunization Records (required for pediatric patients)

5. Current Medications (please bring your medicine bottles with you to your appointment)

To qualify for the sliding fee scale discount, please bring the following items that apply to you (documents cannot be more than 30 days old):

- Last 2 Recent Pay Stubs or Current Tax Return
- Statement from Social Security (Earnings Record/SSI/Disability/Award Letters/Retirement Statements)
- Bank Statements with Recent Deposits
- Child Support Statement
- Food Stamps Summary
- Letter from Current Employer (must have company letterhead, phone number, and address to confirm employment)

If you are in need of a sliding fee scale application, please speak to a patient service representative.