



Part of Spartanburg Regional Physician Group

Michael J. Orseck, MD • Shawn A. Birchenough, MD
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The Village at Pelham • 2755 South Highway 14, Suite 2100 • Greer, South Carolina 29650 • 864.849.9330

Today's Date: _____

Reason for Visit: _____

Billing Information

Responsible Party, Parent, or Guardian (Person—who is responsible for bills):

Name: _____ Relationship: _____

Date of Birth: ____/____/____ Social Security #: _____ Sex: Male [] Female []

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

Patient Information

First Name: _____ M.I.: _____ Last Name: _____

Date of Birth: ____/____/____ Primary Physician: _____

Social Security #: _____ Sex: Male [] Female [] Marital Status: Single [] Married [] Divorced [] Widowed []

Street Address: _____ City: _____ State: _____ Zip: _____

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

Home Phone: (____) _____ Cell Phone: (____) _____ Work Phone: (____) _____

Email Address: _____ would you like to receive email specials from Magnolia Plastic Surgery: YES [] NO []

Employer: _____ Phone: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Emergency Contact: _____ Relationship: _____ Emergency Contact Phone: _____

Student Status: [] Full-Time [] Part-Time [] Not a Student Primary Language Spoken: _____

Ethnic Origin: [] White/Caucasian not of Hispanic origin [] Black/African American not of Hispanic origin [] Hispanic [] Asian or Pacific Islander
[] American Indian or Alaskan native [] Some other race/Multiracial [] Unavailable/Unknown [] Declined

How did you hear about our practice?

[] Physician Referral, if yes, what physician _____ [] Friend [] Website

[] Patient of Magnolia Plastic Surgery [] Advertisement (magazine, newspaper, etc), what source? _____

[] Other (please explain) _____

Is this visit for: [] Cosmetic [] Reconstructive [] Injury [] Other -- Please specify: _____

[] Work Injury Date of Injury: _____ Type of Injury: _____

Preferred Method of Contact & Release

How would you like to be contacted regarding appointments, treatment and/or other information pertinent to your healthcare provided at Magnolia Plastic Surgery?

Any method: [] Home Phone: [] Work Phone: [] Cell Phone: [] Mail: []

The staff and doctors of Magnolia Plastic Surgery have my permission to leave all necessary messages regarding the patient listed above on the voicemail or answering machine located at the phone numbers listed on the patient's information sheet. [] Yes [] No

- I do not authorize any information to be disclosed to any other parties except to me as the patient. Patient Initials: _____
I authorize the person(s) listed below to receive all health information about appointments, treatment and/or other information pertinent to my healthcare and/or payment for my healthcare provided at Magnolia Plastic Surgery. Patient Initials: _____

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____



MAGNOLIA PLASTIC SURGERY

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Insurance & Financial Information

Primary Insurance Company: _____ Effective Date: ____/____/____
Name of Policy Holder: _____ Relationship: _____
Policy Holder Social Security Number: _____ Date of Birth: ____/____/____
Policy Holder Address *(if different from the person responsible for the bill)*
Mailing Address: _____ City: _____ State: _____ Zip: _____
Policy #: _____ Group #: _____
Employer: _____ Employer Phone Number: _____

Secondary Insurance Company: _____ Effective Date: ____/____/____
Name of Policy Holder: _____ Relationship: _____
Policy Holder Social Security Number: _____ Date of Birth: ____/____/____
Policy Holder Address *(if different from the person responsible for the bill)*
Mailing Address: _____ City: _____ State: _____ Zip: _____
Policy #: _____ Group #: _____
Employer: _____ Employer Phone Number: _____

Financial Arrangements and Medical Insurance Acknowledgement of Notice of Privacy Practices

We are committed to providing you with the best possible care. If you have medical insurance, we are eager to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of our payment policy.

Payment for services (including co-pays and deductible) are due at the time services are rendered. We accept cash, checks, and most major credit cards. This office will cooperate with individuals covered by insurance. We ask that you read your policy and be sure that you are fully aware of any limitations of the benefits provided. You should look upon your insurance realistically as a device that helps in reimbursement for medical expenses.

You must realize; however, that:

- Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.
- All charges are your responsibility from the date services are rendered.
- Cosmetic procedures are not covered by insurance.

I acknowledge that I have received a copy of the Notice of Privacy Practices at Spartanburg Regional Healthcare System and have reviewed the Financial Policy for Magnolia Plastic Surgery.

Patient/Guardian Signature: _____ Date: _____



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Health Habits & Family History

Exercise: Sedentary Mild exercise Occasional vigorous exercise Regular vigorous exercise
Caffeine: NONE Coffee Sodas ___ Number per day Tea
Alcohol: Yes No How often? _____
Tobacco: NONE Cigarettes ___ packs per day ___ Number of years using tobacco products ___ Year quit using tobacco products
 Other: _____
Drugs: Do you currently use recreational or street drugs? Yes No

Are there any significant medical problems in your family? If so please list all medical issues for family members.

IMMEDIATE FAMILY MEMBER (parents/siblings)	MEDICAL PROBLEM(S)

ALLERGIES:

Are you allergic to any of the following: (check all that apply) *Please give specific reaction.

YES	NO	REACTION	YES	NO	REACTION
<input type="checkbox"/>	<input type="checkbox"/>	aspirin _____	<input type="checkbox"/>	<input type="checkbox"/>	erythromycin _____
<input type="checkbox"/>	<input type="checkbox"/>	codeine _____	<input type="checkbox"/>	<input type="checkbox"/>	iodine _____
<input type="checkbox"/>	<input type="checkbox"/>	demerol _____	<input type="checkbox"/>	<input type="checkbox"/>	morphine _____
<input type="checkbox"/>	<input type="checkbox"/>	penicillin _____	<input type="checkbox"/>	<input type="checkbox"/>	sulfa drugs _____
<input type="checkbox"/>	<input type="checkbox"/>	tetracycline _____	<input type="checkbox"/>	<input type="checkbox"/>	latex _____

List additional drugs/items that cause allergic reactions (including tape, latex, foods, etc.):

Complete this section *only if you have had Bariatric surgery:*

Open Bypass Laparoscopic Bypass Lap-Band Bariatric Physician: _____

Highest Weight: _____ Current Weight: _____ Length of time at current weight: _____

Do you currently have or have you ever had a rash? _____

How long have the rash(s) occurred? _____

Where do they occur: _____ How do you treat them: _____

What physician do you see for treatment of rashes?

Physician: _____

Name of Practice: _____

Phone Number (if known): _____



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Photographic Authorization and Release

By my signature below, I authorize my physician at Magnolia Plastic Surgery (Michael J. Orseck, MD or Shawn A. Birchenough, MD) and/or his associates to photograph me and/or make electronic recordings of me (hereafter referred to as photographic or electronic reproductions) in connection with the plastic surgery procedure(s) he has performed or may perform. This consent includes the taking of photographic or electronic reproductions of any part of my body.

I authorize the use of any such photographic or electronic reproductions of me for purposes of my treatment, education endeavors, insurance preauthorization and quality assurance review. I hereby grant permission for the use of any of my medical records including illustrations, photographs, or other imaging records created in my case, for use in examination, testing, credentialing and/or other imaging records created in my case, for the use in examination, testing, credentialing and/or certifying purposes by The American Board of Plastic Surgery, Inc. To the extent that I am not identifiable from such photographic or electronic reproductions, they may be used for any purpose, including but not limited to scientific or education purposes or publication in newspaper, magazines, and other public media as my be deemed appropriate by Michael J. Orseck, MD or Shawn A. Birchenough, MD.

I understand that I may refuse to consent to the taking of any photographic or electronic reproductions that are not intrinsic to my operation or procedure without prejudice to my care.

Neither I, nor any member of my family, will be identified by name in any form of publication. Wherever possible, the photos will be cropped so as to show only the pertinent information, but not personally identifying information. I understand that in some circumstances, the photographs may portray features that will make my identity recognizable.

I have entered into this agreement in order to assist scientific treatment, educational, public relations and/or charitable goals and herby waive any right for compensation for these uses. I and my successors and assignees hereby waive any right for compensation for these uses. I and my successors and assignees hereby hold Michael J. Orseck, MD or Shawn A. Birchenough, MD, his employees, and any other person participating in my case and their successors and assignees harmless against any claim for injury or compensations resulting from the activities authorized by this consent.

Patient Printed Name

Printed Witness Name

Patient Signature

Witness Signature

Date



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GENERAL CONSENT TO TREAT/ PATIENT AUTHORIZATION/ACKNOWLEDGEMENT OF BENEFITS RELEASE

The following are the conditions for services provided by the Magnolia Center for Plastic Surgery which is affiliated with Spartanburg Regional Health Services District, Inc. (District) for the patient whose name appears at the bottom of this page.

CONSENT FOR MEDICAL TREATMENT

I/we voluntarily consent to medical treatment and diagnostic procedures provided by Spartanburg Regional 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.

AUTHORIZATION FOR RELEASE OF INFORMATION

The practice and physicians are authorized to release any medical information required in the processing of applications or submission of information for financial coverage, discharge planning and further medical treatment. To include information referring to psychiatric care, sexual assault or tests for infectious diseases including AIDS/HIV for services provided during this visit. I/we also agree to the release of medical or other information about me to government federal or state regulatory agencies as required by law.

ASSIGNMENT OF INSURANCE BENEFITS

I/we guarantee payment of all charges made for or on account of the patient and I/we assign our rights in any insurance benefits or other funding to the physician and Spartanburg Regional. I/we understand that I/we am/are responsible for any charges not covered by insurance or other forms of benefits. I/we understand Spartanburg Regional can obtain my/our credit report for review in collection of this debt. In the event that this account is placed with a collection agency or attorney for collection or collected following the SC Setoff Debt Collection Act, I/we shall pay all collections fees and costs, including reasonable attorney's fees. For Medicare beneficiaries: I/we have provided all necessary information for proper assignment of Medicare benefits.

WORKER'S COMPENSATION PATIENT RECORDS RELEASE AND AUTHORIZATION FORM

I understand that South Carolina and North Carolina Worker's Compensation law provides that written information which pertains directly to a workers' compensation claim must be provided by a healthcare facility/physician to the insurance carrier, the employer, the employee, their attorneys, or the applicable State Workers' Compensation Commission pursuant to the SC Code Ann § 42-15-95 and NC ST § 97-27. **I authorize Spartanburg Regional Healthcare System (SRHS) to provide copies of my medical records or to speak to duly authorized representatives of any of the above regarding my medical records, medical treatment, or condition.**

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I/we have received a copy of the Notice of Privacy Practices. The notice describes how my health information may be used or disclosed. I understand that I should read it carefully. I am aware that the Notice may be changed at any time. The Notice of Privacy Practices may be accessed at www.srhs.com.

Date and Time

Signature of Patient/(Relationship to Patient)
(Parent, Guardian or Legally Authorized Representative)

Hospital Witness

Signature of Guarantor (Relationship to Patient)



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