PRIMARY CARE

SOUTH COUNTY HEALTH

WELCOME

Thank you for choosing our practice for your medical needs. We value our relationship with you and want to serve as your 'Personal Medical Home.'

On your first visit, you will meet with our staff and your medical practitioner. As a primary care medical practice, we will address your current and future medical needs in an effort to detect or prevent any medical conditions. Your first visit is an opportunity for us to get acquainted and address any medical concerns you may have.

Enclosed/Attached please find our important medical forms, which we ask you to complete prior to your visit and return to us either by dropping off, faxing or mailing within **two weeks of your appointment**. *If you are unable to submit these forms prior to your appointment please arrive 20 minutes prior to your appointment time.*

Forms to be completed prior to your appointment:

- ☐ Patient Demographic
- ☐ Medical history form
- ☐ Financial, Cancellation, and Medication Refill policy
- ☐ Authorization for release of Protected Health Information
- ☐ Consent for treatment form
- ☐ Permission to speak form

Day of your appointment:

- ☐ Please bring your current medical card(s) and if necessary please make sure that your insurance carrier is aware you are choosing one of our providers as your Primary Care Physician.
- ☐ Please bring photo identification

If you are unable to keep your appointment or need to reschedule please call our office.

We look forward to welcoming you to South County Health Primary Care!

EAST GREENWICH

3461 SOUTH COUNTY TRAIL, SUITE 301
EAST GREENWICH, RI 02818
TELEPHONE: 401-471-6760
FAX: 401-471-6765

NARRAGANSETT

14 WOODRUFF AVENUE, SUITE 1
NARRAGANSETT, RI 02882
TELEPHONE: 401-789-8543
FAX: 401-782-8766

WARWICK

120 CENTERVILLE ROAD
WARWICK, RI 02886
TELEPHONE: 401-562-1020
FAX: 401-562-1056

WESTERLY

268 POST ROAD, SUITE 203
WESTERLY, RI 02891
TELEPHONE: 401-604-2530
FAX: 401-604-2560

SOUTHCOUNTYHEALTH.ORG

SOUTH COUNTY HEALTH

SOUTH COUNTY MEDICAL GROUP
PRIMARY CARE

PATIENT INFORMATION AND INSURANCE FORM

First Name: _____ MI: _____ Last Name: _____

Preferred Name: _____ DOB: _____ Gender: ☐ Male ☐ Female

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____

Email: _____

Occupation: _____ Employer Phone: _____

Preferred Communication: ☐ Home Phone ☐ Cellphone ☐ Text

Race *(choose one)*:

☐ American Indian / Alaska Native
☐ African American
☐ Asian
☐ Native Hawaiian / Pacific Islander
☐ White / Caucasian
☐ Other / Decline

Ethnicity *(choose one)*:

☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Declined

Marital Status *(choose one)*:

☐ Single
☐ Married
☐ Divorced
☐ Widowed
☐ Other

INSURANCE INFORMATION

Primary Insurance Plan: _____

Policy Number: _____ Group Number *(if any)*: _____

Claims Address: _____

Policy Holder Name & DOB: _____ Relationship to Patient: _____

Secondary Insurance Plan: _____

Policy Number: _____ Group Number *(if any)*: _____

Claims Address: _____

Policy Holder Name & DOB: _____ Relationship to Patient: _____

Emergency Contact: _____ Relationship to Patient: _____

Phone Number: _____

Preferred Pharmacy Name: _____ Address: _____

LEGAL

Do you have a medical durable power of attorney? ☐ Yes ☐ No Do you have an advanced directive? ☐ Yes ☐ No

If yes to either, please provide the office with a copy of the legal documents for our files.

Patient Name: _____ DOB: _____

MEDICAL HISTORY

Allergies *(list ALL medication, food, and environmental allergies):* _____

_____

_____

Medications *(Please list ALL medications prescribed or OTC with dose and frequency)*: _____

_____

_____

_____

Please bring copies of all immunization records

Past Medical History *(choose all that apply)*:

- ☐ A-Fib
- ☐ ADD / ADHD
- ☐ Anxiety / Depression
- ☐ Asthma
- ☐ Blood / Clotting Disorder
- ☐ Benign Prostatic Hyperplasia
- ☐ Chicken Pox
- ☐ Colon Polyps
- ☐ Concussion
- ☐ Congestive Heart Failure
- ☐ Coronary Artery Disease
- ☐ Crohn's Disease
- ☐ Deep Vein Thrombosis
- ☐ Dementia / Alzheimer's Disease
- ☐ Diabetes, Type I
- ☐ Diabetes, Type II
- ☐ Emphysema / COPD
- ☐ Epilepsy / Seizures
- ☐ Erectile Dysfunction
- ☐ Fibromyalgia
- ☐ Gallbladder Disease
- ☐ Gastroesophageal Reflux (GERD)
- ☐ Glaucoma
- ☐ Gonorrhea, Chlamydia, Herpes, Other
- ☐ STD
- ☐ Headaches / Migraines
- ☐ Hearing Loss
- ☐ Heart Disease / Heart Attack
- ☐ Hemorrhoids or Rectal Disease
- ☐ Hepatitis A, B or C
- ☐ Hernia
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Irritable Bowel Syndrome (IBS)
- ☐ Kidney Stones / Kidney Disease
- ☐ Lung Nodules
- ☐ Lyme Disease
- ☐ Mental Illness / PTSD
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Peptic Ulcers
- ☐ Pneumonia
- ☐ Psoriasis
- ☐ Pulmonary Embolism
- ☐ Rheumatic Fever
- ☐ Rheumatoid Arthritis
- ☐ Seasonal Allergies
- ☐ Sleep Apnea
- ☐ Stroke / TIA
- ☐ Systemic Lupus Erythematosus
- ☐ Thyroid Disease / Hypo or Hyper
- ☐ Tuberculosis
- ☐ Ulcerative Colitis
- ☐ Other: _____

_____

_____

Have you ever been diagnosed with cancer? ☐ Yes ☐ No

If yes please specify type of cancer and date of diagnosis: _____

_____

Surgical History *(list ALL past surgeries)*: _____

_____

Do you use any Assistive Devices? ☐ Cane ☐ Walker ☐ Wheelchair ☐ Hearing Aids ☐ Support Cane (for seeing impaired)

Do you see any specialist? *(If yes, please list their names and specialty)* _____

_____

Patient Name: _____ DOB: _____

Tobacco: Do you smoke? ☐ Yes ☐ Former ☐ Never If yes/former, how many packs per day? _____

Alcohol: Do you drink alcohol? ☐ Yes ☐ Former ☐ Never If yes/former, how frequently? _____

Other: Do you use any illegal substances? ☐ Yes ☐ No Have you been treated for substance abuse problems? ☐ Yes ☐ No

Safety: Are there guns in your home? ☐ Yes ☐ No Do you wear a seatbelt? ☐ Yes ☐ No

Health Maintenance:

Date of last Physical Exam: _____ Date of last Colonoscopy: _____

Date of last Tetanus Vaccine: _____ Date of last Pneumovax Vaccine: _____

Women ONLY:

Age at menses onset: _____ Date of last period: _____

Date of last PAP: _____ Colposcopy/Biopsy/Surgery: _____

Name of GYN: _____ Number of Pregnancies: _____

Number of Children: _____ Pregnancy Complications: _____

Men ONLY:

Weak Urine Stream: ☐ Yes ☐ No Discharge from Penis: ☐ Yes ☐ No

Painful/Swollen Testis: ☐ Yes ☐ No Prostate Trouble: ☐ Yes ☐ No

Review of Symptoms *(Choose ALL that apply within the past 6 months):*

- ☐ Black Stool
- ☐ Bloody Sputum / Vomit
- ☐ Bruise Easily
- ☐ Chest Pain
- ☐ Cough (Unexplained)
- ☐ Diarrhea
- ☐ Difficulty Swallowing
- ☐ Dizziness
- ☐ Ear Pain / Discharge
- ☐ Excess Sweating
- ☐ Fainting
- ☐ Fatigue
- ☐ Fever / Chills
- ☐ Hair / Nail Problem
- ☐ Hearing Problems
- ☐ Heart Palpitations
- ☐ Heartburn
- ☐ Incontinence
- ☐ Increased Thirst
- ☐ Itching
- ☐ Joint Pain
- ☐ Muscle Aches/Weakness
- ☐ Nausea
- ☐ Nighttime Urination
- ☐ Nose Bleeds
- ☐ Numbness
- ☐ Poor Appetite
- ☐ Rectal Bleed
- ☐ Rectal Discomfort
- ☐ Ringing of Ears
- ☐ Sexual Problems
- ☐ Shortness of Breath
- ☐ Skin Problems
- ☐ Swollen Feet
- ☐ Throat Discomfort
- ☐ Trouble Sleeping
- ☐ Trouble with Vision
- ☐ Unexpected Weight Gain
- ☐ Unexpected Weight Loss
- ☐ Urgent Urination
- ☐ Urination Problems
- ☐ Voice Change
- ☐ Wheezing

FAMILY HISTORY

Has any of your **FIRST** or **SECOND** degree relatives been diagnosed with any of the following health conditions? If so, **please specify who the relative is and if it is maternal or paternal side.** If history of cancer or heart disease, please **indicate age** when diagnosed.

Cancer: _____ Stroke: _____

Type: _____ Mental Illness: _____

_____ Alcoholism: _____

Diabetes: _____ Suicide: _____

Thyroid Disease: _____ Asthma: _____

High Cholesterol: _____ Early Death *(prior to 55 years old)*: _____

High Blood Pressure: _____ Heart Disease: _____

SOUTH COUNTY HEALTH

SOUTH COUNTY MEDICAL GROUP

ACKNOWLEDGMENT OF **FINANCIAL, NO-SHOW, CANCELLATION** AND **MEDICATION REFILL POLICY**

☐ I hereby authorize South County Health to furnish information to insurance carriers concerning my illness and treatment process to process my claim. I hereby assign all payment for medical services rendered to myself or my dependents. In the event that the patient is a minor, I attest that I am the parent and/or legal guardian of said patient and agree that I am responsible for all costs related to services rendered to the patient herein.

☐ I understand all current and prior patient balances including coinsurance and deductibles are due at the time of service and that I will present my ID and insurance cards at every visit.

☐ I understand that in order to book any appointments I will be required to put a credit/debit card on file that will be specifically used if I am late or do not attend an appointment.

☐ I understand that a $50.00 charge will be assessed if I do not show up for my appointment or call to cancel my appointment within 24 hours of my appointment.

☐ I understand arriving after my scheduled appointment time may result in having to reschedule my appointment, and a $50 fee will be charged.

☐ I understand my credit/debit card will not be charged for any past due balances without my permission.

☐ I understand I am required to call my pharmacy for refills and must allow 2 business days for those refills to be processed.

Patient Name: _____ DOB: _____

Guardian Name: _____ Relationship: _____

I acknowledge that I have received a copy of this document and reviewed it. I agree to comply with these terms and acknowledge that any fees incurred are my responsibility.

Patient/Guardian Signature: _____ Date: _____

SOUTH COUNTY HEALTH

SOUTH COUNTY MEDICAL GROUP

FINANCIAL, NO-SHOW, CANCELLATION AND MEDICATION REFILL POLICY

CREDIT CARD AUTHORIZATION FORM

CARDHOLDER INFORMATION – print only

Name on Card: _____

Billing Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____

Email Address: _____

CREDIT CARD INFORMATION

☐ Visa ☐ MasterCard ☐ AMEX ☐ Discover

Credit Card Number: _____

Expiration Date (MM/YY): _____ / _____ CVV: _____

PAYMENT AUTHORIZATION

I authorize South County Health System to charge the credit card indicated in this authorization form according to the terms outlined below. This payment is for:

No-show or cancellation of appointment in accordance with the Financial, No-show / Cancellation and Prescription Refill Policy that I have received

Amount to be Charged: $ 50.00

AUTHORIZATION

I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company, so long as the transaction corresponds to the terms indicated in this form.

Signature: _____ Date: _____

SOUTH COUNTY HEALTH

PATIENT NAME: _____

DOB: _____

MRN: _____

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

1. I authorize South County Health (SCH) to obtain/release/exchange my health information specific to the following date or time period: _____ or ☐ All episodes of care

   RECORDS FROM: ☐ South County Hospital ☐ South County Medical Group ☐ South County Home Health

2. ☐ **OBTAIN FROM:**

   Provider: _____

   Address: _____

   _____

   Phone: _____

   Fax: _____

   ☐ **RELEASE TO:**

   _____

   Address: _____

   _____

   Phone: _____

   Fax: _____

3. Patients may elect to have copies of their medical record provided electronically.
   Please check ☐ to indicate your wish to have your medical records provided in an electronic format.
   Email address: _____

4. Purpose for which disclosure is to be made: _____

5. Information to be disclosed/exchanged:

   ☐ Discharge Summary
   ☐ History and Physical Exam
   ☐ Consultations
   ☐ Medications
   ☐ Other: _____
   ☐ Operative Report
   ☐ Pathology
   ☐ Emergency Dept. Report
   ☐ Office Notes
   ☐ Progress Notes
   ☐ Laboratory Report
   ☐ Radiology Report
   ☐ PRINT ☐ ELECTRONIC ☐ BOTH
   EXAM: _____

   I understand this may include health information relating to *(check if applicable)*:

   ☐ HIV (Human Immunodeficiency Virus) infection
   ☐ Treatment for alcohol and/or drug abuse
   ☐ Behavioral Health
   ☐ Genetic Testing

6. I understand that if the person(s) or entity(s) that receives the information is not a health care provider or health plan covered by federal privacy regulation, the information described above may be re-disclosed and is no longer protected by those regulations. Therefore, I release SCH, its employees and contractors from all liability arising from this disclosure of my health information. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

7. I understand that SCH may receive compensation for the authorized use/disclosure of this information.

PLEASE CONTINUE TO PAGE 2 AND COMPLETE THE AUTHORIZATION.

SOUTH COUNTY HEALTH

PATIENT NAME: _____

DOB: _____

MRN: _____

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

PAGE 2: AUTHORIZATION

8. I understand that I may inspect or request copies of any information disclosed by this authorization. It is my understanding that this authorization will expire in 90 days from the date signed below. I understand that I may revoke this authorization by notifying, in writing, the department that provided the information, knowing that previously disclosed information would not be subject to my revoke request.
9. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment or my eligibility for benefits.
10. I understand that this authorization shall be retained as a part of my protected health information in accordance with applicable SCH policy. I have received a copy of this authorization.
11. This authorization expires on _____ or ninety days from the date this authorization was signed. I further understand that I may revoke this authorization in writing at anytime except to the extent that action has been taken on it.

Patient or Legal Representative: _____ Date: _____

Witness Signature: _____ Date: _____

Relationship to Patient if Signature Not Patient: _____

☐ Photo ID verified By: _____ Receipt Date/Time _____ / _____

MAIL, FAX, OR EMAIL THE COMPLETED FORM TO:

South County Health
Health Information Management
100 Kenyon Avenue
Wakefield, RI 02879

FAX: 401-789-5571
EMAIL: medrecrelease@southcountyhealth.org

SOUTH COUNTY HEALTH

SOUTH COUNTY MEDICAL GROUP

GENERAL CONSENT FOR TREATMENT

Patient Name: _____ DOB: _____

Practice Name: _____

1. I, the undersigned and/or legal representative or relative, hereby consent to, authorize and request South County Medical Group and its medical personnel to perform ambulatory care services, including but not limited to medical examinations, evaluations, treatments, procedures, diagnostic tests, laboratory tests, vaccinations and immunizations during the course of my or the patient's care as may be deemed advisable or necessary. I understand that I have the right to refuse any suggested medical treatment, examination, evaluation or test at any time.
2. I understand that this consent and authorization for treatment is valid and will remain in full force and effect for the duration of my treatment at this Facility unless and until I revoke or otherwise withdraw my consent in writing.
3. I understand and agree that I am ultimately responsible for all charges associated with the ambulatory care services that I receive at this Facility. In the event that my insurance company does not pay for the anticipated portion of any charges, for any reason, I understand and agree to be responsible for all unpaid amounts.
4. I have been given a copy of and had an opportunity to review and understand the SCCHS Joint Notice of Privacy Practices. I understand and acknowledge that this Notice describes how my protected health information may be used or disclosed for carrying out medical treatment, billing and payment activities and other healthcare operations. I hereby consent to and authorize such use and disclosure of my protected health information.
5. Consent to obtain medication history:
   I understand that an accurate medication history is very important to helping treat my condition and to avoid potentially dangerous drug interactions. I agree that SCCHS may request and use my prescription medication history from other healthcare providers and/or third party pharmacy benefit payers for treatment purposes.

Patient Signature or Authorized Person: _____ Date: _____

Witness Signature: _____ Date: _____

Relationship if Signature is Not Patient: _____

SOUTH COUNTY HEALTH

SOUTH COUNTY MEDICAL GROUP

REQUEST FOR CONFIDENTIAL COMMUNICATIONS

Patient Name: _____ DOB: _____

I request that **ALL COMMUNICATIONS** from:

Name of Practice: _____

Check off Preference(s):

☐ For **WRITTEN** communications:

- ☐ Addressed to: _____
  _____
  _____
- ☐ Secure Email: _____

☐ For **ORAL** communications:

- ☐ The best number to call: _____
- ☐ May we leave a message? ☐ Yes ☐ No

Who may we discuss your medical condition with if necessary *(not including your physician)*?

Name: _____

Relationship to Patient: _____ Telephone: _____

Medical Durable Power of Attorney? ☐ Yes* ☐ No **Please present documentation* Form Provided? ☐ Yes ☐ No

Name: _____

Relationship to Patient: _____ Telephone: _____

Medical Durable Power of Attorney? ☐ Yes* ☐ No **Please present documentation* Form Provided? ☐ Yes ☐ No

Patient Signature: _____ Date: _____

WELCOME TO SOUTH COUNTY **MEDICAL GROUP PATIENT PORTAL**

To access your health record, please use the instructions below to enroll and begin viewing your health information online.

SOUTH COUNTY HEALTH

You may be receiving this invitation because you have recently been scheduled for an appointment or have recently been seen by a provider at one of our South County Medical Group practices. All patients will need to enroll, following the instructions below, to access your medical records.

If you are a **NEW USER** and are setting up access to your own health record or to someone else's health record, follow these directions:

1. The patient portal prefers Google Chrome. Portal performance issues may occur with outdated browsers if you use Firefox, Microsoft Edge or Safari. Internet Explorer is not supported by South County Medical Group Portal.
2. An invitation will go to your email provided at registration in your medical record. This email will provide a link to create your username, password, and security question by clicking on **"Click here to sign in".**
   a. Temporary username and password will be filled in for you, all you need to do is click **"Sign in"**.
   b. This will bring you to a page where you will need to create:
      - Login ID that must:
        - Contain no fewer than 4 characters, with no limit on max characters
        - Contain no special characters
      - Password must:
        - Contain no fewer than 10 characters, with no limit on max characters
        - Contain a minimum of 1 upper, lower, and special character
      - You will need to create a security question using options available and provide an answer.
   c. Once completed hit **"Continue".**
   d. Read and accept user agreement.
   e. This will bring you to Home Page of your patient portal or medical records.
3. Second way to sign up for portal is by visiting the Medical Group Portal website at **SouthCountyHealth.org/patientportal** or scan the QR code to the right.
   a. Click on the "Start here!" button.
      - You will need to enter the following information under **"Create an Account"**:
        - Last Name (required)
        - First Name (required)
        - Date of Birth (required) including MM/DD/YYYY
        - Email Address is required and must match what we have in your medical chart. This will need to be entered twice

SCMG PATIENT PORTAL

MEDICAL GROUP PATIENT PORTAL ALLOWS YOU TO:

- ✓ View medical records
- ✓ View visit history and documentation
- ✓ Exchange secure messages with providers
- ✓ Schedule office appointments or virtual visits
- ✓ Pay bills online for accounts starting with "SM"
- ✓ Complete pre-visit questionnaires

SOUTH COUNTY MEDICAL GROUP PATIENT PORTAL INCLUDES ACCESS TO:

- Center for Women's Health
- Infectious Disease
- General Surgery
- Nephrology
- Primary Care
- Pulmonology
- Urology

PLEASE NOTE: THERE ARE TWO PATIENT PORTALS

If you need to access your medical records for a hospital or Express Care visit, or to pay bills online with accounts starting with "V", please login to the South County Hospital Patient Portal at **MySCHPortal.com**.

If you have **ALREADY SIGNED UP FOR THE SOUTH COUNTY MEDICAL GROUP PATIENT PORTAL** and want to access your health record, please login through the SCH NOW app.

Our SCH NOW app makes it easy for patients to access high-quality healthcare from their smartphones or another personal device. Download at **SOUTHCOUNTYHEALTH.ORG/APP**

- Get Care NOW
- Test Results
- Locations
- Find a Provider
- Bill Pay
- Careers

SCH-240 0323