WELCOME TO USC PULMONARY, CRITICAL CARE, AND SLEEP MEDICINE

OFFICE/BILLING POLICY: We accept most insurance plans. Payment is due when services are provided. For your convenience we accept cash, checks and credit cards (sorry no Discover Card or American Express). It is your responsibility to fully understand your coverage benefits and to verify that we are listed as approved providers prior to scheduling an appointment with us.

INSURANCE COVERAGE: Please bring your insurance card and a valid identification card to your scheduled appointment. Without verification of your insurance coverage, your appointment may be rescheduled, or you will be expected to pay all fees at the time services are rendered. If your insurance carrier requires referral authorizations, it is your responsibility to check with your primary care physician to ensure they have authorized your visits to your office. Without this authorization you will be expected to pay for the services you receive, on the date of your appointment, in full. You are expected to pay all copays and deductibles at the time of your visit. Failure to pay your copay or deductible may result in your next appointment being rescheduled until payment is made.

SELF-PAY: If you do not have valid health care coverage, you will be considered as a self-paying patient. Payment in full is required when services are rendered. Financial arrangements can be made if necessary; however, a minimum of $100.00 will be expected on the day of your visit. Any supplies used or testing done will be extra and not included in the $100.00 minimum. Should you wish to speak with someone regarding the initial payment and/or a payment plan, please contact Kim Gilbert at (803) 540-1108.

UNPAID BALANCES: Should you accrue a balance due on your account, you must pay the balance in full prior to your next scheduled appointment or make arrangements for payment prior to the visit. Failure to pay or make arrangements may result in your appointment being cancelled or rescheduled.

NO SHOWS: We use an automated appointment reminder system that will call you 48-hours prior to your appointment. Please listen carefully to the message and press "1" to confirm the appointment and "2" to cancel the appointment. If you need to cancel for any reason, please contact us at (803) 799-5022. If you are not at home, a message will be left on your answering system. Failure to notify us of a cancellation prior to 48-hours before your appointment will result in a charge of $25.00. Should you have an emergency that prevents you from attending your appointment, please contact us as soon as possible at (803) 799-5022. Should you fail to show up for or call to alert us of not being able to attend your appointment for three scheduled appointments, then you will be dismissed from care from that physician. You will receive notice via certified mail that you have been dismissed as a patient from the practice.

LATE FOR APPOINTMENTS: If you are more than 20 minutes late for your scheduled appointment, then you will have to reschedule your appointment for another time. Issues with public transportation may possibly be taken into consideration if the doctor’s schedule permits.

PULMONARY FUNCTION TESTS: Please arrive 15 minutes early if you are scheduled for a pulmonary function test. If you arrive after your appointment time, you will be asked to reschedule your appointment.

WALK-IN CLINIC: We are very excited to offer this service!! This clinic is for established patients only. If you are sick and feel you need to be seen in the clinic, please come to our office between 7:30am and 8:30am for the walk-in clinic. We strongly encourage you to arrive by 8:00am if you want to be seen in the clinic that day.

COMPLAINTS: Should you have any concerns about your visits or service here, please contact the office manager, Lisa Cathcart, at (803) 454-2695, or you may notify us in writing at:
USC School of Medicine
Division of Pulmonary, Critical Care, and Sleep Medicine
One Medical Park, Suite 300
Columbia, SC 29203

______________________________________________________
Patient’s Signature/Guardian’s Signature        Date
# UNIVERSITY SPECIALTY CLINICS
## Patient Registration

**PATIENT INFORMATION**

<table>
<thead>
<tr>
<th>Field</th>
<th>Details</th>
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</thead>
<tbody>
<tr>
<td>Patient Name</td>
<td>_____________________________________</td>
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<tr>
<td>Sex</td>
<td>M   F</td>
</tr>
<tr>
<td>Race</td>
<td>_____________________________________</td>
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<tr>
<td>DOB</td>
<td>____________________ / ______ / ______</td>
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<tr>
<td>Address</td>
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<tr>
<td>City</td>
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<td>State</td>
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<td>Zip</td>
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<td>County</td>
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<td>Home phone#</td>
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<tr>
<td>Work phone #</td>
<td>____________________</td>
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<tr>
<td>Cell Phone #</td>
<td>____________________</td>
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<tr>
<td>Social Security #</td>
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<tr>
<td>Marital Status</td>
<td>_____________________________________</td>
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<tr>
<td>Email Address</td>
<td>_____________________________________</td>
</tr>
<tr>
<td>Primary Care Physician</td>
<td>_____________________________________</td>
</tr>
<tr>
<td>Employer Name/Address</td>
<td>_____________________________________</td>
</tr>
</tbody>
</table>

**EMERGENCY CONTACT** (*Not your home phone please*)

<table>
<thead>
<tr>
<th>Field</th>
<th>Details</th>
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</thead>
<tbody>
<tr>
<td>Name</td>
<td>_____________________________________</td>
</tr>
<tr>
<td>Phone#</td>
<td>____________________</td>
</tr>
<tr>
<td>Relationship</td>
<td>_____________________________________</td>
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</tbody>
</table>

**PERSON RESPONSIBLE FOR PAYING (IF DIFFERENT FROM PATIENT)**

*Or Subscriber for primary insurance*

<table>
<thead>
<tr>
<th>Field</th>
<th>Details</th>
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<tbody>
<tr>
<td>Responsible Person’s Name</td>
<td>_____________________________________</td>
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<tr>
<td>Relationship to patient</td>
<td>_____________________________________</td>
</tr>
<tr>
<td>Address</td>
<td>_____________________________________</td>
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<tr>
<td>City</td>
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<td>State</td>
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<td>Zip</td>
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<td>County</td>
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<td>Home phone#</td>
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<td>Work phone #</td>
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<td>DOB</td>
<td>____________________</td>
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<tr>
<td>Social Security #</td>
<td>____________________</td>
</tr>
<tr>
<td>Employer Name and Address</td>
<td>_____________________________________</td>
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</tbody>
</table>

**INSURANCE INFORMATION**

1. **INSURANCE COMPANY:** ____________________ Phone#: ____________________ Employer________________________
   - Mailing Address: ___________________________________________________________________________
   - Policy#: ____________________ Group#: ____________________ Subscriber’s Name________________________
   - Subscriber’s Birth Date___________________ Subscriber’s SS #: ____________________ Relationship to patient____________________

2. **INSURANCE COMPANY:** ____________________ Phone#: ____________________ Employer________________________
   - Mailing Address: ___________________________________________________________________________
   - Policy#: ____________________ Group#: ____________________ Subscriber’s Name:________________________
   - Subscriber’s Birth Date___________________ Subscriber’s SS #: ____________________ Relationship to patient____________________

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**Patient Signature**

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Revised 06/03/10

*patinf2*
USC PULMONARY PATIENT QUESTIONNAIRE

(Please complete prior to your office visit)

Name: ___________________________ Age: ______ Date: ____________

Reason for Visit: ___________________________ Referring MD: ___________________________

SYMPTOMS: Please check all current symptoms

- Cough
- Sputum production
- Coughing up blood
- Wheezing
- Sinus Drainage
- Sore Throat
- Fever
- Chills
- Night Sweats
- Leg swelling
- Weight Loss
- Chest pain
- Shortness of breath at rest
- Shortness of breath with exertion
- Sleep on several pillows or in a chair
- Stop breathing while sleeping
- Waking up short of breath

Med Allergies □ No □ Yes  Please list drugs and reactions: _______________________________________

Preferred pharmacy ____________________________________________

MEDICAL HISTORY: please check all conditions that you have or have had

<table>
<thead>
<tr>
<th>Condition</th>
<th>Condition</th>
<th>Medication Name</th>
<th>Dose</th>
<th>Times per day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asthma</td>
<td>Anemia</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Emphysema</td>
<td>Sickle Cell Disease</td>
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<tr>
<td>Tuberculosis</td>
<td>High Blood Pressure</td>
<td></td>
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</tr>
<tr>
<td>Allergies</td>
<td>Hypo/Hyperthyroidism</td>
<td></td>
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<tr>
<td>Sarcoidosis</td>
<td>Migraine Headaches</td>
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<tr>
<td>Sleep Apnea</td>
<td>Seizures</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Heart Failure</td>
<td>HIV</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Heart Attack</td>
<td>Stroke</td>
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<tr>
<td>Hypertension</td>
<td>Mental illness</td>
<td></td>
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<tr>
<td>Diabetes</td>
<td>Glaucoma</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stomach Ulcer</td>
<td>Cancer or Leukemia</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Liver Disease</td>
<td>Type: Other:</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Arthritis</td>
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<tr>
<td>Gout</td>
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<tr>
<td>Kidney Stones</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kidney Failure</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

SURGICAL HISTORY:

Surgery: ___________________________ Year: ____________  Surgery: ___________________________ Year: ____________

Surgery: ___________________________ Year: ____________  Surgery: ___________________________ Year: ____________

SOCIAL / PERSONAL HISTORY: Please complete the following information about yourself

Occupation: Type of work you have done in the past:

□ Unemployed □ Retired □ Disabled

Marital Status: □ Married □ Single □ Widowed □ Separated □ Divorced

Tobacco Use: □ Never □ Current

□ Quit □ Age you quit: ____________

Type: □ Cigars □ Pipe □ Dip □ Cigarettes

Age you started: ________ # packs/day ________

# of Years smoked: ________

Exposed to: □ Second hand smoke □ Asbestos □ Chemical fumes □ Radiation □ Mining

Alcohol Use: □ Never □ Occasionally ( __ drinks per __) Daily □ Quit □ Type: □ Beer □ Wine □ Liquor

Drug Use: □ Never □ Occasionally □ Daily

Types: ____________________________

Exercise: □ Regularly □ Occasionally ( __ per __) □ Rarely
FAMILY HISTORY: List any medical problems

<table>
<thead>
<tr>
<th>Father:</th>
<th>Mother:</th>
<th>Brother/Sister:</th>
<th>Grandparents:</th>
</tr>
</thead>
</table>

REVIEW OF SYSTEMS: please check any item which describes recent or ongoing symptoms

- **General:**
  - □ Significant weight loss
  - □ Loss of feeling of well-being
  - □ Fatigue or loss of energy
  - □ Difficulty sleeping
  - □ None apply
  - Comment: ____________________________________________________________________________

- **Eyes:**
  - □ Blurred vision
  - □ Double vision
  - □ Seeing spots
  - □ Eye pain
  - □ Need glasses
  - □ Cataract
  - □ Glaucoma
  - □ None apply
  - Comment: ____________________________________________________________________________

- **Ear – Nose – Throat:**
  - □ Hearing loss
  - □ Ringing in your ears
  - □ Dizziness
  - □ Sore throat
  - □ Breath odor
  - □ Hoarseness
  - □ Chronic nasal congestion
  - □ Sinus infections
  - □ Nose bleeds
  - □ Toothaches /Bleeding gums
  - □ None apply
  - Comment: ____________________________________________________________________________

- **Respiratory:**
  - □ Shortness of breath
  - □ Cough
  - □ Chest congestion
  - □ Wheezing
  - □ Coughing up blood
  - □ Choking
  - □ Noisy breathing
  - □ History of pneumonia
  - □ History of or exposure to tuberculosis (TB)
  - □ None apply
  - Comment: ____________________________________________________________________________

- **Cardiovascular:**
  - □ Chest pain
  - □ Heart fluttering or racing
  - □ Heart murmur
  - □ Decreased exercise tolerance
  - □ Awakenings due to shortness of breath
  - □ Difficulty breathing when lying down
  - □ Leg swelling
  - □ Pain in buttocks or legs with exercise
  - □ Sensitivity of hands or feet to temperature changes
  - □ None apply
  - Comment: ____________________________________________________________________________

- **Breast:**
  - □ Breast lump
  - □ Breast pain
  - □ Breast cancer
  - □ None apply
  - Comment: ____________________________________________________________________________

- **Gastrointestinal:**
  - □ Stomach pain
  - □ Nausea
  - □ Vomiting
  - □ Diarrhea
  - □ Constipation
  - □ History of taking diet pills
  - □ Frequent heartburn/ Indigestion
  - □ Belching or sour taste
  - □ Difficulty swallowing
  - □ Bloating
  - □ History of hepatitis/ yellow jaundice
  - □ Rectal bleeding
  - □ Rectal pain or irritation
  - □ Hemorrhoids
  - □ None apply
  - Comment: ____________________________________________________________________________

- **Genitourinary (Men only):**
  - □ Frequent urination
  - □ Pain on urination
  - □ Prostate problems
  - □ None apply
  - Comment: ____________________________________________________________________________

- **Genitourinary (Women only):**
  - □ Frequent urination
  - □ Pain on urination
  - □ Frequent urinary infections
  - □ Blood in urine
  - □ None apply
  - Comment: ____________________________________________________________________________

- **Lymphatic / Hematologic:**
  - □ Unusual lymph node swelling
  - □ Painful lymph nodes
  - □ History of cancer type:
  - □ History of anemia
  - □ Blood clots
  - □ Bruise easily
  - □ Unusual bleeding
  - □ None apply
  - Comment: ____________________________________________________________________________

- **Musculoskeletal:**
  - □ Limb or joint pain
  - □ Limb or joint swelling / stiffness / redness
  - □ Muscle weakness
  - □ Loss of muscle bulk
  - □ Muscle spasms or twitching
  - □ Recurring back pain
  - □ Neck pain
  - □ Back injury
  - □ Neck injury
  - □ None apply
  - Comment: ____________________________________________________________________________

- **Neurologic:**
  - □ Seizures
  - □ Tremors
  - □ Unusual cluminess
  - □ Limb weakness
  - □ Numbness / tingling
  - □ Stroke
  - □ Passing out
  - □ History of head injury
  - □ Chronic headaches
  - □ None apply
  - Comment: ____________________________________________________________________________

- **Psychologic / Sleep:**
  - □ Lapse in memory
  - □ Confusion
  - □ Difficulty concentrating
  - □ Depression
  - □ Mood swings
  - □ History of mental illness
  - □ History of physical or mental abuse
  - □ Snoring
  - □ Daytime sleepiness
  - □ None apply
  - Comment: ____________________________________________________________________________

- **Endocrine:**
  - □ Unexpected changes in:
  - □ Tolerance to heat
  - □ Tolerance to cold
  - □ Unusual thirst
  - □ None apply
  - Comment: ____________________________________________________________________________

- **Allergy / Immunology:**
  - □ Seasonal allergies
  - □ Frequent or unusual infections (ie. Bronchitis)
  - □ Sensitivity to specific items:
  - □ None apply
  - Comment: ____________________________________________________________________________

- **Skin:**
  - □ Itching
  - □ Rash
  - □ Unusual dryness
  - □ Changes in hair
  - □ Changes in pigmentation
  - □ None apply
  - Comment: ____________________________________________________________________________

- **MD or NP Signature:** ___________________________  Date: ___________________________
Authorization Regarding Payment and Release of Medical Information

Patient’s Name: _______________________________ Chart #: ________________

I hereby authorize and request the payment of services from Medicare, Medicaid and/or other insurance plans or payors be made on my behalf to University Specialty Clinics – Department of Internal Medicine. I hereby assign to University Specialty Clinics – Department of Internal Medicine all payments for treatment services. I hereby allow University Specialty Clinics to file an appeal for me with Medicare, Medicaid and/or other insurance plans or payors for any reason. I understand and agree that I am responsible for paying any amount not covered by Medicare, Medicaid and/or other insurance plans or payers.

(PLEASE READ THE ATTACHED FINANCIAL AND INSURANCE POLICY FOR OUR PRACTICE)

I hereby authorize the release of medical information to Medicare, Medicaid and/or insurance plans or other payers. I also authorize the release of medical information to other healthcare providers including, but not limited to, my primary care or family physician, consulting physicians or healthcare providers, hospitals, rehabilitation center, or other healthcare providers or facilities. I authorize my healthcare providers to review my prescription history from my pharmacist(s) for purposes of treatment. I permit a copy of this authorization to be used.

Patient's/Representative's Signature

Date

Printed patient’s or Representative’s Name

Representative’s relationship to Patient

Consent to Treatment

I hereby agree to and give consent to the physicians, healthcare providers, associates, and consultants of University Specialty Clinics – Department of Internal Medicine, and residents of affiliated institution, Palmetto Health, to diagnose and treat me. I consent to any and all treatment including, but not limited to, physical examinations, psychological examinations, x-rays, laboratory procedures, and other procedures related to routine diagnosis and treatment as determined appropriate by the practice’s physicians, healthcare providers, associates, consultants and residents.

I give permission to share my electronic medical record among my healthcare providers and obtain medication history through a Provider Health Information Exchange (HIE). The University Specialty Clinics will not provide sensitive information such as behavioral health, substance abuse treatment, sexual abuse, genetic test results, HIV/STD status and adoption records, unless mandatory disclosure is required by state or federal law. I MAY OPT OUT OF THE HIE BY COMPLETING THE OPT-OUT FORM AND CONTINUE TO RECEIVE CARE.

Patient’s/Representative’s Signature

Date

Printed patient’s or Representative’s Name

Representative’s relationship to Patient

Revised 2/2/2015
FINANCIAL POLICY

Credit is extended to those patients who need it. However, our policy is
CREDIT ARRANGEMENTS MUST BE MADE BEFORE SERVICES RENDERED

By making arrangements in advance for time payment and keeping your account current, you can avoid the risk of future credit problems with this office.

INSURANCE

Payment of medical fees is the responsibility of the patient. Your insurance company accepts your premium and is responsible to you for reimbursement. We will furnish you with enough information and assistance to file claims BUT we cannot be responsible for collecting your insurance payments. We will allow 45 days for your insurance company to pay assigned claims at which time we will hold you the patient responsible for payment of the account. All co-payments must be made at the time services are rendered. No exceptions.

Patient Initials: __________
University Specialty Clinics Notice of Privacy Practices

By signing below, I state that I have been given my own copy of the University Specialty Clinics’ Notice of Privacy Practices, effective date 4/14/03.

___________________________________  ____________________
Printed Name of Patient      Signature of Patient      Date

OR

___________________________________  ____________________
Printed Name of Patient’s Representative      Signature of Patient’s Representative’s      Date

Description of Authority to Act on Behalf of Patient
Communication with Friends, Family, or Others Involved in Your Care

If you are present and do not object, University Specialty Clinics providers may discuss or share your health information with family members, friends, or others involved in your care or payment for your care. We may (1) ask your permission, (2) may tell you we plan to discuss the information and give you an opportunity to object, or (3) may decide, using our professional judgment, that you do not object. We may discuss only the information that the person involved needs to know about your care or payment for your care.

If you are not around or cannot give permission, we may share or discuss your health information with family, friends, or others involved in your care or payment for your care if we believe, in our professional judgment, that it is in your best interest. When someone other than a friend or family member is asking about you, we must be reasonably sure that you asked the person to be involved in your care or payment for your care. We may only share the information that the family member, friend, or other person needs to know about your care or payment for your care. University Specialty Clinics will verify the identity of any person not known to us prior to disclosing health information.

If you would like to name specific family, friends, or others involved in your care or payment for your care whom you would like us to share your health information, please list them in the space provided below. If you are not around or cannot give permission, we may rely on this information until you notify us otherwise; however, we may use our professional judgment to determine whether sharing your health information with these or other individuals is in your best interest.

<table>
<thead>
<tr>
<th>Name of Family Member, Friend, or Other Person Involved in Patient’s Care or Payment for Care</th>
<th>Relationship to Patient/Involvement with Patient’s Care or Payment for Care</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

Signature of Patient or Patient’s Legally Qualified Representative

Date

Printed Name

Relationship to Patient if not the Patient
Call (803) 799-5022 with any questions on directions

**Chapin, Irmo, Newberry on I-26**

- From I-26 follow I-126 into Columbia & then take Elmwood Avenue into Columbia.
- Follow Elmwood until it “dead ends” at Bull Street.
- Turn Left on Bull Street and then turn right at the third light (Harden Street).
- Go to front entrance of Palmetto Health Richland Hospital and turn left.
- Make the first left and you will be looking at One Medical Park. A gated parking lot is available to left of the building.
- Enter front of building & take elevator to the 3rd floor, Suite 300.

**Charleston, Orangeburg on I-26**

- Take I-77 toward Charlotte, then I-20 toward Augusta, then 277 to Downtown Columbia. 277 ends at Bull Street.
- Turn Left on Bull Street and then turn right at the third light (Harden Street).
- Go to front entrance of Palmetto Health Richland Hospital and turn left.
- Make first left and you will be looking at One Medical Park. A gated parking lot is available to the left of the building

**Lugoff/Elgin, Florence on I-20**

- Take I-20 to 277 Downtown Columbia exit, 277 ends at Bull Street.
- Turn left at the light onto Harden Street (CVS Drugstore on the corner).
- Go to front entrance of Palmetto Health Richland Hospital and turn left.
- Make first left and you will be looking at One Medical Park. A gated parking lot is available to the left of the building

**Blythewood, Charlotte, Winnsboro on I-77**

- Take 277 to Downtown Columbia. 277 ends at Bull Street.
- Turn left at the light on Harden Street (CVS Drugstore on the corner).
- Go to front entrance of the Palmetto Health Richland Hospital and turn left.
- Make first left and you will be looking at One Medical Park. A gated parking lot is available to the left of the building.

**In Town**

- Take Bull Street, going away from downtown, to Harden Street and turn left.
- ** From Forest Acres area going toward downtown, turn right on Harden Street.
- Go to front entrance of Palmetto Health Richland Hospital and turn right.
- Make first left and you will be looking at One Medical Park. A gated parking lot is available to the left of the building