Sandhills OB-GYN Associates, P.A.

Jonathan O. Nwanagu, M.D.
Board Certified by the
American Board of
Obstetrics & Gynecology

PATIENT REGISTRATION

(PLEASE PRINT; COMPLETE **ALL ITEMS** THOROUGHLY)

PATIENT INFORMATION

PATIENT NAME _____ _____ AGE _____
(LAST) (FIRST) (MI)

HOME PHONE _____ MOBILE _____ EMAIL _____

ADDRESS _____
(STREET) (CITY) (STATE) (ZIP) (COUNTY)

DOB _____ SS# _____ MARITAL STATUS _____

Who referred you to us? MD / FAMILY / FRIEND / INTERNET / OTHER _____

PRIMARY CARE PHYSICIAN _____ PHONE _____

PREFERRED PHARMACY _____ PHONE _____

ADDRESS _____

EMPLOYER _____ OCCUPATION _____

EMPLOYER ADDRESS _____ NUMBER _____

NAME OF SPOUSE _____ SPOUSE'S EMPLOYER _____ PHONE _____

EMERGENCY CONTACT _____
(NAME) (PHONE) (RELATIONSHIP)

ADDRESS _____

RESPONSIBLE PARTY

NAME _____ RELATIONSHIP _____

ADDRESS _____
(STREET) (CITY) (STATE) (ZIP)

HOME PHONE _____ WORK PHONE _____

EMPLOYER _____ ADDRESS _____

SIGNATURE _____ **DATE** _____

Sandhills OB-GYN Associates, P.A.

Jonathan O. Nwanagu, M.D.
Board Certified by the
American Board of
Obstetrics & Gynecology

INSURANCE INFORMATION

PRIMARY INSURANCE	**SECONDARY INSURANCE**
INSURANCE COMPANY _____	INSURANCE COMPANY _____
POLICYHOLDER'S NAME_____	POLICYHOLDER'S NAME _____
SS#_____ DOB_____ SEX___	SS#_____ DOB_____ SEX___
POLICY#_____GROUP# _____	POLICY#_____GROUP# _____
EMPLOYER/GROUP NAME _____	EMPLOYER/GROUP NAME _____

PATIENT HIPAA CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. You have read, understand and have been provided with a copy of our notice of privacy practices. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy by submitting your request in writing or by reviewing the current copy in our waiting room. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or healthcare operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and healthcare operations. You authorize Sandhills OB/GYN to release your personal health information to:

_____

Name Address Phone Number

_____

Name Address Phone Number

_____

Signature of Patient/Legal Guardian Relationship to Patient Date

_____ _____

Patient/Legal Guardian Name Printed Witness Signature Date

Financial Agreement

I certify that all of the information provided is correct. I hereby authorize direct payment of surgical/medical benefits to Sandhills OB/GYN for services rendered by them in person or under their supervision. It is my responsibility to notify the insurance company prior to admission if precertification is necessary. I understand that I AM FINANCIALLY RESPONSIBLE FOR ANY BALANCE NOT COVERED BY MY INSURANCE. I further understand that if my account is turned over to a collection agency, finance charges of 1.5% per month (18% per year) will be added to invoices.

Sandhills OB-GYN Associates, P.A.

Jonathan O. Nwanagu, M.D.
Board Certified by the
American Board of
Obstetrics & Gynecology

Consent for Treatment

I hereby agree and give consent to the treating physician and employees of this office and other associates to diagnose and treat the patient named on this form. I consent to any and all treatment including, but not limited to, physical examinations and other procedures related to the routine diagnosis and treatment of the patient as determined necessary and appropriate by the treating physician, his/her partner, associates, and consultants.

I agree to and give my consent to all of the above information.

Signature of Patient/Legal Guardian	Relationship to Patient	Date

Patient/Legal Guardian Name Printed	Witness Signature	Date

Sandhills OB-GYN Associates, P.A.

Jonathan O. Nwanagu, M.D.
Board Certified by the
American Board of
Obstetrics & Gynecology

Compound Authorization for Release of Information

This authorization form permits Dr. Jonathan Nwanagu, Sandhills OB/GYN, Associates, P.A. (P.O. Box 7481, Columbia, SC 29202) to use or disclose protected health information listed in the Description section below to the Entity or Person listed in the Receiving Entity section for the following patient:

Name: _____ Birth Date: _____

Receiving Entity: Please indicate those entities or persons you wish to get the described information about you.	**Description of information to be given to corresponding Entity or Person.**
Voicemail #	Appointment Time Results of lab test or x-rays Other
Spouse (Provide name)	Financial information Medical information - please list
Parent (Provide name)	Financial information Medical information - please list
Other (Provide name)	Financial information Medical information - please list

Purpose

The purpose of this authorization is to meet the patient's request for information disclosures and uses. **Expiration date or event:** This authorization shall be enforced until revoked by the patient or _____.

Rights of the Patient

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

I understand that I have the right to revoke this authorization at any time by sending a written notification to the address listed at the bottom of this form. I understand that a revocation is not effective in cases where the information has already been used or disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

_____Date_____Signature of Patient or Personal Representative

Description of Personal Representative's Authority (attach necessary documentation): _____

_____ _____ _____

Patient/Legal Guardian Name Printed Witness Signature Date

Sandhills OB-GYN Associates, P.A.

Jonathan O. Nwanagu, M.D.
Board Certified by the
American Board of
Obstetrics & Gynecology

Payment Policy and Agreement

____ 1. **Insurance**. We participate in most insurance plans. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we are in contract with but don't have an up-to-date insurance card, payment will be required in full until we can verify your coverage. Knowing your insurance benefits is your responsibility. If you have a HSA/HRA (High Deductible) insurance plan, payment is required at time of service. Please contact your insurance company with any questions you may have regarding your coverage.

____ 2. **Co-Payments and Deductibles.** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. **Failure on our part to collect co-payments and deductibles from patients can be considered fraud**.

____ 3. **Non-covered Services**. Please be aware that some services you receive may not be covered by your insurance carrier. You must pay for these services at the time of your visit.

____ 4. **Proof of Insurance**. All patients must complete our patient information form before seeing the doctor. We must obtain a scan of your driver's license and current insurance card. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of the claim or be asked to re-schedule.

____ 5. **Claims submission**. We will submit your claims and assist you in any way we can to help you get your claims paid. However, your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware your claim balance is your responsibility whether or not the insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company. **Please contact your insurance company to be sure your plan's requirements have been met and that all referral and prior authorizations are in place before seeking care**.

____ 6. **Coverage changes**. If your insurance changes, please notify us before your next visit so we can make the appropriate changes. If your insurance company does not pay your claim in 60 days, the balance will be automatically billed to you. We do not re-file claims.

____ 7. **Nonpayment**. If your account is over 90 days past due, you will receive a letter stating you have 14 days to pay your account in full. Partial payments will not be accepted unless prior financial arrangements were made. If a balance remains unpaid, we may refer your account to a collection agency. If the account is turned over to a collection agency, finance charges of 1.5% per month (18% per year) will be added to invoices.

____ 8. **Discharged patients**. You may be discharged from this practice if you fail to fulfill your financial obligation. If this happens, you will be notified by certified mail that you have 30 days to find alternative medical care. During that 30 day period the doctor will only see you on an emergency basis.

____ 9. **Laboratory Fees**. Fees for services (pap smear, culture or biopsy, bloodwork) performed by an outside laboratory are your responsibility. If you should have any questions regarding those fees, please call the telephone number directly on the invoice.

Our practice is committed to providing the best treatment to our patients. Our fees are set according to the usual and customary fees for our specialty and area.

Thank you for understanding our payment policy and agreement. If at any time you have any questions or concerns regarding your care, we are here for you.

I have read and understand the payment policy and agree to abide by its guidelines.

_____
Patient Name (Print)

_____ _____
Patient Signature or responsible party Date

Sandhills OB-GYN Associates, P.A.

Jonathan O. Nwanagu, M.D.
Courtney M. Hillen, MSN, CNM

Authorization for Release of Protected Health Information

Patient's Name at the time of treatment: _____

Patient's Address: _____

Date of Birth: _____ Social Security Number: _____

Date(s) of treatment: _____

Purpose of release: _____

I authorize to release my health records to:

Clinic Name: _____
Address: _____
City, State, Zip: _____
Phone: _____
Fax: _____

I authorize to release my health records from:

Clinic Name: _____
Address: _____
City, State, Zip: _____
Phone: _____
Fax: _____

_____Mail Record _____ Patient Pickup _____ Send via Fax

Information to be released: (Please check all that apply.)

___ Entire Medical Record
___ Physician Notes
___ Office Notes
___ Pathology Reports
___ Cytology Reports
___ Mammography Films
___ Laboratory Report
___ EKG/Cardiovascular
___ Pulmonary Function Test
___ Radiology Reports
___ Operative Report
___ Other _____

1) I understand that if my records contain documentation of alcohol abuse, psychiatric condition, drug abuse, or communicable diseases, this information will be released as part of my record.
2) I understand that if this person or entity receiving this information is not covered by federal privacy regulations, this information will no longer be protected and may be re-disclosed.
3) I understand that I may revoke this authorization at any time, but revocation will not apply to information that has already been released. Revocations should be sent to the address noted at the top of the form.
4) I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment.
5) I understand the charge for obtaining the requested information will be $.65 per page for the first 30 pages, $.50 per page for all additional pages and a $15.00 clerical fee.
6) I understand that this authorization will expire 90 days after signed unless an earlier date is specified here _____.

_____ _____
Signature of patient or authorized person Date

_____
Relationship/Reason patient is unable to sign

Verification Completed by _____

Sandhills OB-GYN Associates, P.A.

Jonathan O. Nwanagu, M.D.
Board Certified by the
American Board of
Obstetrics & Gynecology

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

SANDHILLS OBGYN is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Our Privacy Officer is: Dr. Jonathan O. Nwanagu
Our Practice Phone Number is: 803-727-1935
Our Mailing Address is: P.O. Box 7481, Columbia, SC 29202

Disclosure of Your Health Care Information

Treatment - We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations.

"On occasion, it may be necessary to seek consultation regarding your condition from other health care providers associated with SANDHILLS OBGYN."

"It is our policy to provide a substitute health care provider, authorized by SANDHILLS OBGYN to provide assessment and/or treatment to our patients, without advanced notice, in the event of your primary health care provider's absence due to vacation, sickness, or other emergency situation."

Payment - We may disclose your health information to your insurance provider for the purpose of payment or health care operations.

"*As a courtesy to our patients, we will submit an itemized billing statement to your insurance carrier for the purpose of payment to SANDHILLS OBGYN for health care services rendered. If you pay for your health care services personally, we will, as a courtesy, provide an itemized billing to your insurance carrier for the purpose of reimbursement to you. The billing statement contains medical information, including diagnosis, date of injury or condition, and codes which describe the health care services received."*

Workers' Compensation - We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

Emergencies -We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

Public Health

As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

Judicial and Administrative Proceedings
We may disclose your health information in the course of any administrative or judicial proceeding.

Law Enforcement.
We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

Deceased Persons.
We may disclose your health information to coroners or medical examiners.

Organ Donation.
We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

Public Safety.
It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

Specialized Government Agencies.
We may disclose your health information for military, national security, prisoner and government benefits purposes.

Marketing.
We may contact you for marketing purposes, as described below:

> *"As a courtesy to our patients, it is our policy to call your home on the evening prior to your scheduled appointment to remind you of your appointment time. If you are not at home, we leave a reminder message on your answering machine or with the person answering the phone. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment."*

Change of Ownership.
In the event that SANDHILLS OBGYN is sold or merged with another organization, your health information/record will become the property of the new owner.

Your Health Information Rights
1) You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that SANDHILLS OBGYN is not required to agree to the restriction that you requested.

2) You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
3) You have the right to inspect and copy your health information.
4) You have a right to request that SANDHILLS OBGYN amend your protected health information. Please be advised, however, that SANDHILLS OBGYN is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.
5) You have a right to receive an accounting of disclosures of your protected health information made by SANDHILLS OBGYN.
6) You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

Changes to this Notice of Privacy Practices
SANDHILLS OBGYN reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, SANDHILLS OBGYN is required by law to comply with this Notice.

SANDHILLS OBGYN is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact: Our Privacy Officer by calling our office. If Our Privacy Officer is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

Complaints
Complaints about your Privacy rights, or how SANDHILLS OBGYN has handled your health information should be directed to Our Privacy Officer, whose name is stated above, by calling our office If Our Privacy Officer is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days. If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

This notice is effective as of April 14, 2003.

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide SANDHILLS OBGYN with my authorization and consent to use and disclosed my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice

_____

Patient's Name (print)

_____ _____

Patient's Signature Date

_____ _____

Authorized Facility Signature Date

Sandhills
OB-GYN Associates, P.A.

Jonathan O. Nwanagu, M.D.

Board Certified - American Board of Obstetrics and Gynecology

Thank you for choosing Sandhills OB/GYN Associates, PA, the office of Dr. Jonathan O. Nwanagu. We want to make sure that you understand our policy on HOSPITAL EMERGENCIES, ADMISSIONS, AND THE DELIVERY OF BABIES.

Dr. Nwanagu performs all hospital inpatient/outpatient procedures at

Prisma Baptist Hospital

The hospital is located at Taylor and Marion in downtown Columbia.

If you require emergency care you should report to

Prisma Baptist Hospital

Dr. Nwanagu is in cross coverage care with other board-certified physicians, names of whom can be furnished upon request.

Once again, thank you for entrusting us with your care. If you have any questions about the above-mentioned policy or need additional information, please do not hesitate to contact us at 803-727-1935.

** I understand that in the event of any emergencies, surgeries, and deliveries I am urged to present at Prisma Baptist Hospital to receive care by Jonathan O. Nwanagu, MD.

_____

Patient Name

_____

Patient Signature/ Date

1333 Taylor Street, Suite 3J - Columbia, S.C. 29201 - (P.O. Box 7481 - Columbia, S.C. 29202) - Tel. (803) 727-1935 - Fax (803) 254-0070