

Greenwood Rheumatology
Tower Pointe Medical Center
105 Vine Crest Court, Suite 600
Greenwood, SC 29646
(P) 864-330-2054
(F) 864-223-7428

The office of Dr. Taylor Mader

We are looking forward to seeing you on _____.

Your appointment is at _____ with Dr. Mader

Welcome to our practice!

Our staff would like to take this opportunity to welcome you to our practice. We are delighted that you have chosen us for your medical needs. At Greenwood Rheumatology, we take great pride in the relationships that we have established with our patients and the ability to give a personalized approach to difficult problems.

As a patient of Greenwood Rheumatology, we appreciate you following the guidelines of the practice which helps us maintain our goals.

Please arrive 15 minutes before your scheduled appointment time with completed paperwork to allow for the registration process. Please do not mail paperwork.

- **There is a \$25 no-show and cancellation fee for all appointments not kept or not cancelled within 72 hours prior to your appointment date unless there is some type of emergency. A credit/debit card number is required at the time of scheduling to secure all new patient appointments.**
- **Cash payments, deductibles and co-payments must be paid at the time of service. Payments for medical services not covered by insurance plans are the patient's responsibility.**
- **We do not accept Medicaid as a secondary insurance.**
- **Self-Pay patients are required to bring \$250 to their initial visit. Additional financial assistance is available.**

- Our Prescription Refill Policy is as follows: Please request refills at your visit. If you call in for refills, they will be called in between the hours of 10am-6pm. Please have the pharmacy name and number on hand when you call. Controlled substances will not be called in or filled after hours. A 24 hour advanced notice is required for all written prescriptions. All patient phone calls or request will be addressed by a nurse within 24 hours.**
- **Our Prescription Refill Policy is as follows: Please request refills at your visit. If you call in for refills, they will be called in between the hours of 10am-6pm. Please have the pharmacy name and number on hand when you call. Controlled substances will not be called in or filled after hours. A 24 hour advanced notice is required for all written prescriptions. All patient phone calls or request will be addressed by a nurse within 24 hours.**

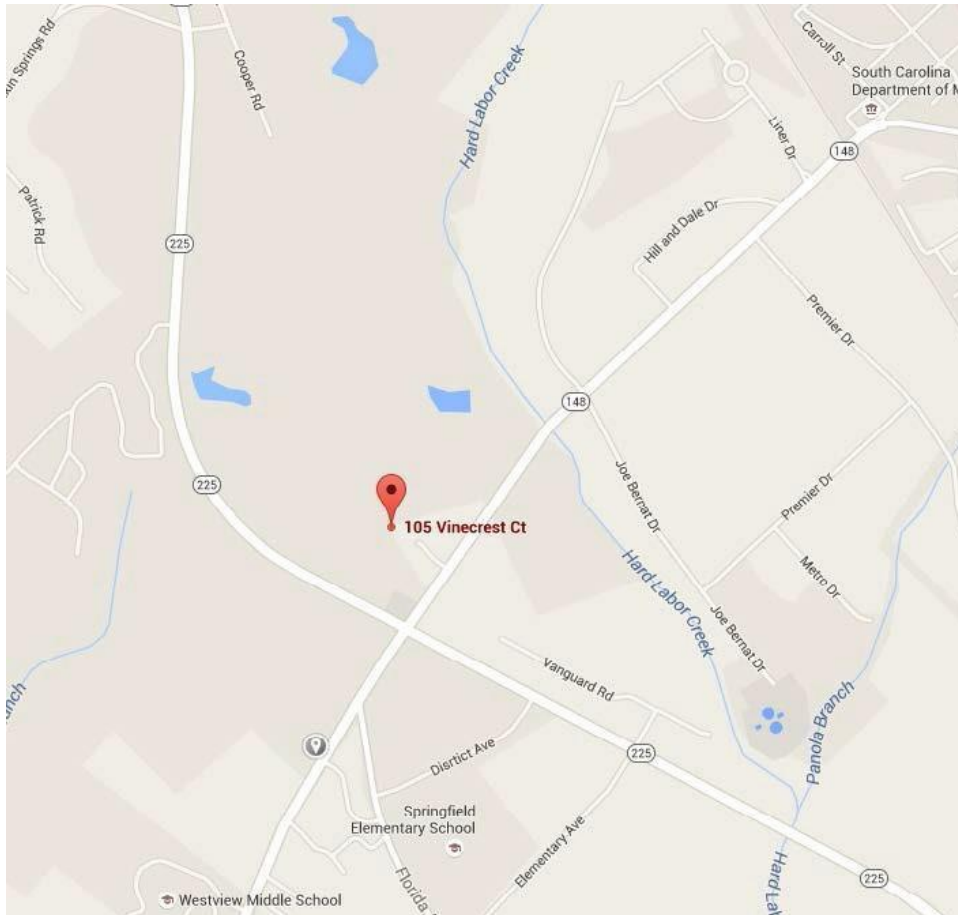
Please bring attached forms, your photo ID and insurance cards to your visit.

Please be aware that if you arrive over 15 minutes late to your appointment you will be asked to reschedule

Please see reverse sides

Directions to the Greenwood Office

105 Vine Crest Ct, Ste 600, Greenwood, SC 29646



* If using a GPS or other navigation system to get to the practice you may need to enter: 1020 Alexander Road West as the address. Vine Crest Court is a private road (not county maintained), and therefore does not show on some commercial maps or GPS devices.*

Last Name		First Name		Middle Intl
Street Address			Apt/Lot #	
City	State		Zip	DOB
Social Security		Circle one: Mr. Mrs. Ms. Miss. Dr.		
Cell Phone ()		Phone Number ()		
Email Address		Employment: Full time Part time Retired Disabled		
Sex M F	Marital Status S M W D		Student? Yes No Full time Part time	

Referring Physician	Phone Number
Primary Care Physician	Phone Number
Spouse	Phone Number
Emergency Contact	Phone Number

Primary Insurance		
Policy Holders Name	DOB	SSN
Policy Number	Group #	Group Name
Secondary Insurance		
Policy Holders Name	DOB	SSN
Policy Number	Group #	Group Name

Consent for Treatment, Payment, and Acknowledgement of Receipt of Notice of Privacy Practices: I request payment under the medical insurance program to be made payable to Greenwood Rheumatology for services rendered. I understand that I am financially responsible for all charges incurred at Greenwood Rheumatology. I authorize disclosure of my personal health information to carry out treatment, payment, or health care procedures. I have received the privacy policy and Notice of Information Practices that provides a more complete Description of information uses and disclosures. I agree to pay any and all charges that exceed or not paid/covered by my insurances. In the event my account is turned over to a collection agency, I will be billed the additional collection fees.

Patient/Guardian: _____

Date: _____

Patient Name: _____ Date Of Birth _____
Reason for visit: _____
Preferred Pharmacy _____ Address _____ City _____ Zip _____

Current medications

- | | |
|---------|----------|
| 1 _____ | 8 _____ |
| 2 _____ | 9 _____ |
| 3 _____ | 10 _____ |
| 4 _____ | 11 _____ |
| 5 _____ | 12 _____ |
| 6 _____ | 13 _____ |
| 7 _____ | 14 _____ |

Medications you have tried in the past for your arthritis condition.

- | | |
|---------|---------|
| 1 _____ | 5 _____ |
| 2 _____ | 6 _____ |
| 3 _____ | 7 _____ |
| 4 _____ | 8 _____ |

Allergies: _____

Prior surgeries: _____

Past medical history: Please list any other diseases or illnesses you have now or have had previously.

- | | |
|---------|---------|
| 1 _____ | 4 _____ |
| 2 _____ | 5 _____ |
| 3 _____ | 6 _____ |

Have you ever smoked cigarettes or tobacco in other forms? YES NO If yes, when you were smoking your heaviest, how many packs per day did you smoke on average: _____ What year did you start smoking? ____ If you subsequently quit, what year did you quit? ____

Do you drink alcohol? YES NO If yes, BEER WINE LIQUOR On average, how many drinks per week? ____ What other physicians care for you; now or in the past?

- | | |
|---------|---------|
| 1 _____ | 3 _____ |
| 2 _____ | 4 _____ |

Is there a history of arthritis or rheumatic disease in your family? Please indicate which family members.

Rheumatoid Arthritis _____ Gout _____
Lupus _____ Psoriasis _____
Other _____

Is your arthritis problem a result of an accident or trauma? YES NO

We do not provide care for problems related to accidents for which there is ongoing litigation for Workman's Compensations. Notify the office if you are unclear about your case.

Disability forms will NOT be completed until you have received six months of established care from our practice

AUTHORIZATION TO RELEASE OR OBTAIN MEDICAL RECORDS
To/From GREENWOOD RHEUMATOLOGY, The office of DR. TAYLOR MADER
(P) 864-330-2054 (F) 864-223-7428, Located at 105 VINE CREST CT, STE 600, GREENWOOD, SC 29646

Patient Name: _____ DOB: _____

Previous Name: (If applicable) _____

Social Security # _____

This authorization expires ONE year from the date of signature

Method of disclosure:

release medical records **FROM** Greenwood Rheumatology to:

Name: _____

Address: _____

Fax #: _____

release medical records **TO** Greenwood Rheumatology from:

Name: _____

Address: _____

Fax #: _____

Health Information to disclose:

ALL health information

Healthcare information relating to the following treatment, condition, or dates

I understand I have the right to refuse to sign this form, and that I may revoke my authorization at any time (except to the extent that the information has already been released). When my information is disclosed, the federal HIPAA Privacy Rule may no longer protect it. This authorization will automatically expire one (1) year from the date of this request or on the following requested date:

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Medical Information Release Form (HIPPA Release Form)

Name:

DOB:

I understand that Greenwood Rheumatology maintains my personal records, medical history, symptoms, examinations, and test results as a part of my healthcare. This information is not to be given to any other person without my permission. Therefore, this is a written consent to authorize release of my medical information.

RELEASE OF INFORMATION

I authorize the release of information including the diagnosis, records, laboratory values, prescribed medications, treatment plan, examination rendered, and claims information. This information may be released to:

Spouse

Child(ren)

Other

Information is **NOT** to be released to anyone

Patient Signature

Date

Witness Signature

Date

GREENWOOD RHEUMATOLOGY PATIENT SCHEDULING POLICY

We are committed to providing our patients with the best possible medical care while also minimizing administrative costs. This scheduling policy has been established with these objectives in mind to avoid any misunderstanding or disagreement concerning payment for professional services.

New Patients

- Due to an increased amount of no-shows and cancellations of New Patient appointments, we are now charging a \$25 fee for all appointments that have not been cancelled 72 hours prior to the scheduled appointment date. A payment of \$25 will be required to schedule and secure all new patient appointments. This payment will be taken over the phone when scheduling the appointment and can be applied to your account for usage of a co-payment upon check-out.
- If you are unable to keep your appointment, kindly call our office at least 72 hours prior to your appointment time. We will work with you to reschedule your appointment to a more convenient time. The \$25 fee will be applied and charged to all appointments not rescheduled 72 hours prior to the appointment date. If you fail to cancel your appointment within 72 hours, your \$25 deposit will be forfeited.
- Cash payments and co-payments must be paid at the time of service. If requested, the \$25 deposit can be applied to your account for usage of a co-payment upon check-out.
- We do not accept Medicaid as a secondary insurance. If Medicaid is secondary, you will be required to sign an agreement understanding that Medicaid will not be accepted.
- Self-Pay patients are required to bring a payment in the amount of \$250 to their initial visit, which will be collected prior to being seen by the doctor. Additional financial assistance is available.
- A physician will review the medical records of all Medicaid and self-referral patients before being scheduled.

Follow Up Appointments

- Established patients with a balance greater than \$100 must clear the outstanding balance with the billing department before scheduling any future appointments. Payment plans can be arranged with the billing manager if necessary.
- Any patient who no-shows or cancels two appointments without giving a 72 hour notice, cannot be rescheduled without a \$50 deposit by credit card.
- If a patient cancels or no-shows three times in a calendar year, they will be discharged from the practice.
- It is the patient's responsibility to keep up with their appointment times. We send automated calls as a courtesy reminder.
- It is the patient's responsibility to obtain any referral needed for a Medicaid/ Tricare Prime insurance for their office visit. If a patient shows up for their office visit without an updated referral, they can pay a \$25 fee for us to obtain the referral or reschedule after they receive the referral.

Our practice firmly believes that a good physician-patient relationship is based upon understanding and good communications. Questions about financial arrangements should be directed to the medical practice. We are here to help you.

PATIENT/ GUARDIAN SIGNATURE: _____

DATE: _____

GREENWOOD RHEUMATOLOGY
PATIENT FINANCIAL POLICY

We are committed to providing our patients with the best possible medical care and also minimizing administrative costs. This financial policy has been established with these objectives in mind and to avoid any misunderstanding or disagreement concerning payment for professional services.

- As the owner of your insurance policy you are solely responsible for the policies regarding your plan.
- Our practice participates with numerous insurance companies. For patients who are beneficiaries of one of these insurance companies, our billing office will submit a claim for services rendered. All necessary insurance information, including any forms, must be completed by the patient prior to leaving the office.
- If a patient has insurance in which we do not participate, our office is happy to file the claim upon request; however, payment in full is expected at the time of service.
- There is a mandatory deposit of \$50 for all existing non-insured patients and \$250 for new non-insured patients. This deposit will be applied to all charges incurred during your visit. If you are unable to make a deposit your visit may be rescheduled.
- It is the patient's responsibility to pay any deductible, copayment, or any portion of the charges as specified by the plan at the time of visit. Payments for medical services not covered by an individual's insurance plan are the patient's responsibility, and payment in full is due at the time of visit.
- Payment for professional services can be made with cash, check, or credit card.
- Financial assistance is available for qualified patients. If a patient feels that he or she may qualify for assistance, the practice receptionist should be notified for referral to the appropriate individual. Patients who do not have insurance are expected to pay for professional services at the time of service unless prior arrangements have been made with us.
- It is the patient's responsibility to ensure that any required referrals or pre-certifications for treatment are provided to the practice prior to the visit. Visits may be rescheduled, or the patient may be financially responsible due to lack of the referral or authorization from their insurance company.
- It is the patient's responsibility to provide us with current insurance information and to bring his/her insurance card to each visit.
- Any patient who no-shows 2 appointments or cancels 2 without giving a 72 hour notice, cannot be rescheduled without a \$50 deposit by credit card. Make sure we have proper documentation in the notes screen.
- If a patient cancels or no-shows 3 times in a calendar year, they will be discharged from the practice.
- It is the patients' responsibility to keep up with their appointment times. We send automated calls as a courtesy reminder.
- It is the patients' responsibility to obtain any referral authorization need for their office visit. If a patient shows up for their office visit without an authorization, they can pay a \$25 fee for us to obtain the PA or reschedule after they receive the PA.
- Our staff is happy to help with insurance questions relating to how a claim was filed, or regarding any additional information the payer might need to process the claim. Specific coverage issues, however, can only be addressed by the insurance company member services department. (Telephone number is printed on the insurance card.)
- If you insurance company request additional information from you, it is important to reply with their requests in a timely manner considering that the balance of your claim and bill is ultimately your responsibility whether or not your insurance company pays your claim. If the insurance company does not pay your claim in 45 days, the balance is billed to and becomes the responsibility of the patient.
- It is your responsibility to notify us with any changes to your insurance coverage, and to make sure we have the proper insurance information. If we do not have the correct insurance information, you are responsible for the total bill.

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PATIENT/ GUARDIAN SIGNATURE: _____

DATE: _____

**GREENWOOD RHEUMATOLOGY
PATIENT REFILL POLICY**

We are committed to providing our patients with the best possible medical care and also minimizing administrative costs. This prescription refill policy has been established with these objectives in mind and to avoid any misunderstanding or disagreement concerning payment for professional services.

Refill request will only be accepted if the following appropriate criteria have been met:

- Physicians will not accept refill requests after hours or on the weekends.
- Refill requests will be submitted to your pharmacy. Please allow 24 hours for this process. You may contact your pharmacy after 24hrs to check on your refill. If there are problems with your refill, you may call our offices only after you have spoken with your pharmacy.
- All narcotic refill requests will take 48 hours to process. You may pick up your prescription at our office no sooner than 48 hours after it was called in.
- Your prescription can only be discussed with a physician, nurse or medical assistant.
- Our office is closed on Fridays. No prescription request will be taken Friday, Saturday or Sunday.
- The requested medication has been ordered previously by a Greenwood Rheumatology physician.
- The patient has been seen by the physician in the last 6 months or it is documented that the physician has ordered a 1year follow up.
- The patient has kept the last scheduled appointment or has been rescheduled for a date within the next 4 weeks.
- A patient requesting DMARDS must have had the required blood work within the last 6-8 weeks. The nurse may arrange for PT to get blood work completed if needed.
- All prescriptions will be written for periods no longer than your next scheduled appointment.
- If a PT misses their appointment and calls in for a prescription, the nurse may only authorize enough medication to meet the patients dosing requirement until the next scheduled appointment. Patients should be worked in within a 1 week maximum.
- No further refills can be authorized unless the next scheduled appointment is kept.

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PATIENT/ GUARDIAN SIGNATURE: _____

DATE: _____
