WELCOME TO AID UPSTATE MEDICAL PRACTICE

Dear New Patient,

Welcome to our practice! Thank you for choosing our providers to participate in your healthcare. We look forward to partnering with you for personalized, comprehensive health care focusing on wellness and prevention. Your medical home team includes providers, nurses, case managers, office staff and most importantly you! Together we will work closely in a "team approach" to support your patient care.

Before your first visit, please notify your health insurance company of your new primary care provider if required. During your initial visit, we will be reviewing your health status, so please bring your health insurance identification card, a photo I.D., and **all of your medications**.

We expect you to be involved in your health care decisions. How can you help?

Be an active team player:

- Ask health questions so you understand your diagnosis and needs.
- Communicate with your medical team.
- Tell us about your other health care providers including visits to an emergency department or urgent care facility.

Take care of your health:

- Set attainable goals.
- Work with the team to develop your health care plan.
- Tell your team if you have trouble following the plan or taking your medications.

Have a checklist ready for your appointment.

- Bring all of your medications with you.
- Bring a list of your questions with you.
- Ask the most important ones first. Write down the answers.
- Before you leave make sure you know what you need to do until your next visit.

Office Hours are Monday through Friday 8:00 am – 5:00 pm
For appointments, cancellations, and prescription refills please call our office during regular office hours or you can send a message through the Patient Portal.

Patient Portal
You can view your lab results, office visit summary, medication lists and much more on our Patient Portal at http://www.aidupstate.org

Appointment Policy
You will need to bring your insurance card, a photo ID, and all of your medications with you for each appointment. We ask that you allow plenty of time to get to the office for your appointment. You will be asked to reschedule your appointment if you are more than 15 minutes late. If for any reason you must cancel or change your appointment please call our office 24 hours prior to your appointment.

Patient-Provider Relationship Termination
While we are committed to a team approach to your medical care, we also expect you will take your role seriously as well. If you decide we're not the team for you, you have the right to seek care elsewhere. Likewise, if you are unable to fulfill your role as an active team member, we may terminate the patient-provider relationship. Termination of the patient-provider relationship within the AID Upstate medical practice does not constitute termination from AID Upstate as an organization unless otherwise stated and relayed to the patient/client in writing.

Termination of the patient-provider relationship may be based on the following patient behaviors:

- Displays a threatening and hostile attitude
- Refuses to cooperate with provider or staff
- Refuses to undergo recommended treatments
- Insists on being his/her "own doctor" and disputes provider judgment
- Fails to follow prescribed diet or self-care regimen
- Abuses prescription drugs or controlled substances
- Fails to return for follow-up appointments

Translation Services
Please let us know one week before your appointment if you require language assistance and we will arrange for an interpreter.

Once again, we would like to thank you for choosing AID Upstate as your health care provider. We look forward to working with you.

Sincerely,

The Providers and Staff of AID Upstate Medical Practice

AID Upstate

PATIENT REGISTRATION

Legal Name: (Last, First, Middle)	Preferred Name:	Date of Birth:
Sex assigned at birth: (please check one) _____Female _____Male Pronouns:_____ *While we recognize all genders/identities; many insurance companies and legal entities unfortunately do not. Please be aware that your legal name and sex you have listed on your insurance must be used on documents pertaining to insurance, billing and correspondence.		
Home Address: (City/ State/ Zip)		
Email Address:	Home Phone #:	Cell Phone #:
Emergency Contact:	Relationship:	Emergency Phone:
Marital Status: _____Married _____Partnered _____Single _____Divorced _____Other		
Ethnicity: _____ Hispanic/Latino _____Not Hispanic/Latino	Race: _____Caucasian _____African American _____ Asian _____American Indian _____Other	Preferred Language:
Insurance Information:		

CONSENT TO TREAT, BENEFIT ASSIGNMENT, AND FINANCIAL POLICY

I consent to medical care and treatment as ordered by a licensed Healthcare Provider and certify that the insurance information listed above is correct. I hereby authorize the release of all information necessary to secure payment of benefits.

AID Upstate participates in the Electronic Health Exchange. This allows patients records to be shared with other participating hospitals and medical practices such as AnMed, Prisma Health System (formally Greenville Health System) and Bon Secours Health System. Your information is not shared without you having an appointment at one of these facilities.

Payment is due at the time services are rendered unless specific arrangements have been made prior to treatment. Our network does participate with a number of insurance plans. Please contact your insurance company to verify participation. If we participate with your insurance carrier, you will be expected to pay your portion of the charge and/or a predetermined copayment on the date of service. We will file your insurance claim. If you are not covered by an insurance plan or sliding fee, payment in full will be expected at the time of service. If this creates a financial hardship for you please inform the receptionist.

_____ _____ _____

Signature of Patient or Legal Guardian | Printed Name of Patient or Legal Guardian | Date

AID Upstate

NOTICE OF PRIVACY PRACTICES
ACKNOWLEDGEMENT FORM

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

SUMMARY:

By law, we are required to provide you with our Notice of Privacy Practices (NPP). The Notice describes how your medical information may be used and disclosed by us. It also tells you how you can obtain access to this information.

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations.

As a patient, you have the following rights:

1. The right to inspect and get a copy of your information
2. The right to request corrections to your information
3. The right to request that your information be restricted
4. The right to request confidential communication
5. The right to a report of disclosures of your information
6. The right to a paper copy of this Notice

We want to assure you that your medical/protected health information is secure with us. The Notice contains information about how we will insure that your information remains private.

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICE

I _____hereby acknowledge that I have been offered a copy of this practice's NOTICE OF PRIVACY PRACTICES. I further understand that the practice will offer me updates to the NOTICE OF PRIVACY PRACTICES should it be amended, modified, or changed in any way.

_____ _____

Patient or Legal Representative Date

AID Upstate

APPOINTMENT POLICY

Welcome to AID Upstate. We are honored that you have chosen us as your specialty health care provider. Our goal is to provide the highest quality care for all of our patients in a timely and respectful manner.

You should plan to arrive 20 minutes prior to your scheduled time. You will need to bring your insurance card, a photo ID and all of your medications with you for each appointment.

We ask that you allow plenty of time to get to the office for your appointment. We will strive to stay on time. From time to time a patient emergency arises and we may be running late for your visit. You will have the option to re-schedule or stay to be seen and we will keep you informed of how long of a delay you may experience.

If for any reason you must cancel or change your appointment, it is important that you give our office at least 24 hours notice to offer that spot to someone else.

Lab results are an important part of your medical visit. If you come to your appointment without having done your labs, your appointment will be rescheduled.

It will be considered a missed appointment if:

- You do not give a 24 hour notice before your appointment time
- You do not call within 1 hour of your appointment in the event of an emergency
- You fail to have your labs done for your appointment

You may leave a message on our voicemail to cancel your appointment. Please leave a number where you can be contacted so we can reschedule your appointment. If you do not cancel please be aware that a missed appointment letter will be mailed to you. Our office may also contact you by telephone about your missed appointment.

Patients in case management who miss 2 consecutive appointments must meet with their case manager before a new appointment time is given.

I have read and understand the AID Upstate appointment policy.

_____

Printed Name

_____

Signature Date

Greenville Office-864-250-0607 Anderson Office-864-226-9505

AID Upstate

Authorization to Release Medical Information to Individuals/Family Members:

In accordance with Federal government privacy rules implemented through the Healthcare portability act of 1996 (HIPAA), In order for your provider or staff of the Practice to discuss your condition with the members of your family or other individuals (**this is someone other than yourself or your provider**) that you designate, we must obtain your authorization prior to doing so.

I authorize AID Upstate to release verbally and/or information, pertaining to my medical care, to the following **family members or individuals below**. I understand this information may only be released to the individual after proper identification has been presented. The authorized person may be requested to obtain this information by appearing in person.

☐ I **do not** authorize AID Upstate to release any printed or verbal information concerning my medical care to any individual.

☐ **I authorize** AID Upstate to release verbally and/or photocopies of any of all information concerning my medical care (appointments, prescriptions, etc) to the following individuals. **NOT** to include photocopies of medical records.

Print Name	Relationship	DOB	Contact #
Print Name	Relationship	DOB	Contact #

Patient Printed Name: _____

Patient Signature: _____ **Date:** _____