Magnolia Plastic Surgery –Spartanburg
391 Serpentine Dr. Ste. 250 Spartanburg, SC 29303
864.560.6717

Magnolia Plastic Surgery –Pelham
2755 S. Highway 14 Ste. 2050 Greer, SC 29650
864.849.9330

Michael J. Orseck, MD
Shawn A. Birchenough, MD

Patient Registration Form

Please print or write legibly

PATIENT INFORMATION

First Name: ________________________ **M.I:** __________ **Last Name:** ____________________

Date of Birth: ______________ **Sex:** M F **Social Security#:** ________________ **Marital Status:** S M LS D W

Mailing Address: ____

City: ______________________________State______________ Zip__________

Street Address (if different from mailing) ________________________________

City: __________________State_____ Zip________ Primary Language________________

Race: [ ] White/Caucasian [ ] Black/African American [ ] Native Hawaiian [ ] AM Indian/Alaska Nat [ ] Asian/E Indian
[ ] Unavailable/Unknown [ ] Declined to Provide ***May choose multiple races***

Ethnicity: [ ] Hispanic/Latino [ ] Not Hispanic/Latino [ ] Declined

Phone: Home: ______________ Cell: ______________ Work: ______________ Preferred Phone: home cell work

Employer/School: ______________Student: FT_____ PT_____ Primary Care Physician: ________________

[If a minor] Childs Fathers Name ____________________Childs Mothers Name________________

[If the patient is a minor child] and the parents are legally separated or divorced please complete the following:
Which parent has legal custody of the minor child? ________________________________
Which parent is financially responsible for the minor child's medical expenses after insurance? ________________

Please provide a copy of the legal documentation stating the parent responsible for medical expenses to be included in the patient's medical record.

Is this visit for: Cosmetic Reconstructive Injury Other -- Please specify: ____________________

Email Address: ________________________ would you like to receive email specials from Magnolia Plastic Surgery: YES NO

Work Injury: **Date of Injury:** __________ **Type of Injury** ________________________________

If a work injury, please give us your human resources manager and/or case manager name and phone # if known:
____

[ ] ***check if same as patient***

GUARANTOR INFORMATION (*person financially responsible for any patient balances*)

Name: ________________________________ Date of Birth: ______________ Sex: M F

Mailing Address: ____________________________ Social Security#: ________________

City: __________________State_____ Zip________ Relationship to Patient: ________________

Phone: Home: ______________ Cell: ______________ Work: ______________ Preferred Phone: home cell work

Employer/School: ______________________________email address: ________________________

Thank You For Choosing Spartanburg Regional For Your Healthcare Needs

INSURANCE INFORMATION *(please provide copies of all medical insurance cards)*

Name of ***Primary*** Insurance: ________________________________Certificate Number____________________________

Group Number _________________________________Co Pay Amount ___________________________Effective Date___________________

SUBSCRIBER INFORMATION (*Person who carries the insurance*) **[ ] *Check here if same as the patient***

Name: ____DOB____

Mailing Address: ____ Social Security#: ________________________________

City: __________________________________State_______ Zip_______________ Relationship to Patient: ___________________________

Phone: Home: ____________________ Cell: ____________________ Work: ______________________ Preferred Phone: home cell work

Employer/School: ____

Name of ***Secondary*** Insurance: ______________________________Certificate Number____________________________

Group Number _________________________________Co Pay Amount ___________________________Effective Date___________________

SUBSCRIBER INFORMATION (*Person who carries the insurance*) **[ ] *Check here if same as the patient***

Name: ____DOB____

Mailing Address: ____ Social Security#: ________________________________

City: __________________________________State_______ Zip_______________ Relationship to Patient: ___________________________

Phone: Home: ____________________ Cell: ____________________ Work: ______________________ Preferred Phone: home cell work

Employer/School: ____

Financial Policy

This information is to provide clarification for patients of Medical Group of the Carolinas regarding matters of insurance, co-pay, deductibles and co-insurance amounts due at the time of service. Physician Group Practices have an obligation to various Healthcare plans to apply any deductible and/or collect any co-payment prior to provision of services.

- **Co-Pays:** You will be required to pay your co-payment upon arrival for your appointment
- **Deductibles and Co-Insurance:** You will be asked at check in or check out for any deductible or co-insurance that may be applicable to your office visit
- **Previous Balances:** You will be expected to provide payment for previous balances or balances sent to collections prior to your office visit. If you are unable to pay your balance in full, you may be asked to set up a payment plan. You may set up this plan with our office or contact Physicians Billing Service at 1-877-596-2455. Physicians billing service is Medical Group of the Carolinas billing service and will be glad to assist you with your questions about any billing inquiry
- **You must realize:**
  - Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.
  - All charges are your responsibility from the date services are rendered.
  - Cosmetic procedures are not covered by insurance.

PLEASE SIGN THE ACKNOWLEDGMENT BELOW

I acknowledge that the above information is true and accurate demographic and insurance information for the patient listed on this registration form. I also acknowledge that by signing this form, I authorize payment of medical benefits to the undersigned physician or supplier for services described. I have also read the above Medical Group of the Carolinas financial policy and agree to the terms of the policy.

Patient Signature____ Parent or Guardian Signature: ________________________________

Thank You For Choosing Spartanburg Regional For Your Healthcare Needs

Patient Name____DOB:______________________

PLEASE INDICATE YOUR PREFERRED METHOD OF CONTACT & HIPAA RELEASE OF INFORMATION

How would you like to be contacted regarding appointments, treatment and/or other information pertinent to your healthcare and/or payment for your healthcare provided at the Medical Group of the Carolinas?

[ ] I may be contacted by "Any Method" **If not "any method" please choose Restricted Contact Preferences**

[ ] Home Telephone [ ] Cell Phone [ ] Work Phone [ ] Mail [ ] E-Mail

May we leave a message on your answering machine/voicemail? [ ] Yes [ ] No

What is your preferred method of contact? [ ] Home Telephone [ ] Cell Phone [ ] Work Phone [ ] Mail [ ] E-Mail

HIPAA DELEGATES

[ ] OPTION 1: THESE ELECTIONS WILL BE IN EFFECT FOR ALL MGC LOCATIONS

I authorize the person (s) listed below to receive all health information about appointments, treatment and/or other information pertinent to my healthcare and/or payment for my healthcare provided at the Medical Group of the Carolinas. These individuals will be designated as my *emergency contacts.*

Name: ______________________________________Relationship:_________________________Phone:__________

Name: ______________________________________Relationship:_________________________Phone:__________

[ ] OPTION 2: THESE ELECTIONS WILL BE IN EFFECT FOR ALL MGC LOCATIONS

I do not authorize any information to be disclosed to any other parties except to me as the patient/guardian except in the event of an emergency. Please note the following are *emergency only contacts*

Name: ______________________________________Relationship:_________________________Phone:__________

Name: ______________________________________Relationship:_________________________Phone:__________

Minor Patient Release

[ ] OPTION 3: MINOR PATIENT RELEASE – THESE ELECTIONS WILL BE IN EFFECT FOR ALL MGC LOCATIONS

I authorize the following individual (s) to consent to medical treatment in my absence

Name: ______________________________________Relationship:_________________________Phone:__________

Name: ______________________________________Relationship:_________________________Phone:__________

PLEASE SIGN AND DATE BELOW

PATIENT/GUARDIAN SIGNATURE: ____**DATE**______________

Medical History

Name: ______________________________ **DOB:** ___________ **Age:** ______ **Height:** ______**ft.** ______**in.** **Weight:** _________**lbs.**

Do you presently have or have you ever experienced the following: (check all that apply)

YES	NO	
☐	☐	abnormal bleeding
☐	☐	blood clots
☐	☐	breast implants
☐	☐	cancer
☐	☐	COPD
☐	☐	diabetes
☐	☐	emphysema
☐	☐	epilepsy or seizures
☐	☐	heart attack
☐	☐	heart disease

YES	NO	
☐	☐	hernia
☐	☐	high blood pressure
☐	☐	high cholesterol
☐	☐	kidney disease
☐	☐	lung disease
☐	☐	psychiatric disease
☐	☐	renal disease
☐	☐	stroke

List all operations, date and hospital:

YEAR	OPERATION	HOSPITAL

Review of Systems: (Check if you currently have any of the following symptoms)

CONSTITUTIONAL
- ☐ Fatigue/Weakness
- ☐ Fever
- ☐ Weight loss
- ☐ Weight gain
- ☐ Swelling in legs

BREAST
- ☐ Breast discharge
- ☐ Breast lumps
- ☐ Breast pain

RESPIRATORY
- ☐ Cough
- ☐ Shortness of breath
- ☐ Spitting up blood
- ☐ Wheezing

CARDIOVASCULAR
- ☐ Chest Pain
- ☐ Heart murmur
- ☐ Short of breath on exertion
- ☐ Palpations

PSYCHIATRIC
- ☐ Anxiety
- ☐ Depression
- ☐ Difficulty sleeping

NEUROLOGIC
- ☐ Dizziness
- ☐ Seizures
- ☐ Syncope (Fainting/Passing out)

HEMATOLOGIC
- ☐ Anemia
- ☐ Easy bleeding
- ☐ Easy bruising
- ☐ Swollen lymph nodes

EYES
- ☐ Vision problems
- ☐ Blurred vision
- ☐ Vision loss
- ☐ Dry eyes

MUSCULOSKELETAL
- ☐ Back pain
- ☐ Bone fracture
- ☐ Joint pain
- ☐ Muscle pain
- ☐ Joint swelling
- ☐ Muscular weakness
- ☐ Numbness
- ☐ Neck pain
- ☐ Shoulder pain

GASTROINTESTINAL
- ☐ Abdominal pain
- ☐ Bloody stool
- ☐ Constipation
- ☐ Nausea
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Vomiting
- ☐ Reflux

INTEGUMENTARY
- ☐ Acne
- ☐ Changes in existing lesions/moles
- ☐ New skin lesions
- ☐ Shoulder grooving/bruising
- ☐ Itching
- ☐ Rash

Are there any other medical conditions we should know about? Please explain:

____

____

Health Habits & Family History

Exercise: ☐ Sedentary ☐ Mild exercise ☐ Occasional vigorous exercise ☐ Regular vigorous exercise

Caffeine: ☐ NONE ☐ Coffee ☐ Sodas ___ Number per day ☐ Tea

Alcohol: ☐ Yes ☐ No How often? ______________________________

Tobacco: ☐ NONE ☐ Former Smoker ☐ Cigarettes ___ packs per day
_________ Year quit using tobacco products _________ Number of years using tobacco products

☐ Other: ____

Drugs: Do you currently use recreational or street drugs? ☐ Yes ☐ No

Are there any significant medical problems in your family? If so please list all medical issues for family members.

IMMEDIATE FAMILY MEMBER (parents/siblings)	MEDICAL PROBLEM(S)

ALLERGIES:
Are you allergic to any of the following: (check all that apply) *Please give specific reaction.

YES	NO		REACTION	YES	NO		REACTION
☐	☐	aspirin	________	☐	☐	erythromycin	________
☐	☐	codeine	________	☐	☐	iodine	________
☐	☐	demerol	________	☐	☐	morphine	________
☐	☐	penicillin	________	☐	☐	sulfa drugs	________
☐	☐	tetracycline	________	☐	☐	latex	________

List additional drugs/items that cause allergic reactions (including tape, latex, foods, etc.):

____

Complete this section *only if you have had Bariatric surgery*:

☐ Open Bypass ☐ Laparoscopic Bypass ☐ Lap-Band Bariatric Physician:

____

Highest Weight: __________ Current Weight: __________ Length of time at current weight: __________
Do you currently have or have you ever had a rash? ______________________________
How long have the rash(s) occurred? ______________________________

Where do they occur: ____________________ How do you treat them: ____________________

What physician do you see for treatment of rashes? ______________________________

Name of Practice: ____________________ Phone Number (if known): ____________________

MEDICATION FORM

Name:
Birth Date:

IMMUNIZATION RECORD (Record the date/year of last dose taken, if known)		
TETANUS	FLU VACCINE(S)	
PNEUMONIA VACCINE	HEPATITIS VACCINE	**OTHER**

LIST ALL MEDICINES YOU ARE CURRENTLY TAKING: prescription and over-the-counter medications (examples: aspirin, antacids) and herbals (examples: ginseng, gingko). Include medications taken as needed (example: nitroglycerin).

DATE	**NAME OF MEDICATION / DOSE**	**DIRECTIONS: Use patient friendly directions. (Do not use medical abbreviations.)**	**DATE STOPPED**	Notes: Reason for taking / Doctor Name

Photographic Authorization and Release

By my signature below, I authorize my physician at Magnolia Plastic Surgery (Dr. Michael Orseck or Dr. Shawn Birchenough) and/or his associates to photograph me and/or make electronic recordings of me (hereafter referred to as photographic or electronic reproductions) in connection with the plastic surgery procedure(s) he has performed or may perform. This consent includes the taking of photographic or electronic reproductions of any part of my body.

I authorize the use of any such photographic or electronic reproductions of me for purposes of my treatment, education endeavors, insurance preauthorization and quality assurance review. I hereby grant permission for the use of any of my medical records including illustrations, photographs, or other imaging records created in my case, for use in examination, testing, credentialing and/or other imaging records created in my case, for the use in examination, testing, credentialing and/or certifying purposes by The American Board of Plastic Surgery, Inc. To the extent that I am not identifiable from such photographic or electronic reproductions, they may be used for any purpose, including but not limited to scientific or education purposes or publication in newspaper, magazines, and other public media as may be deemed appropriate by Michael J. Orseck, MD or Shawn A. Birchenough, MD.

I understand that I may refuse to consent to the taking of any photographic or electronic reproductions that are not intrinsic to my operation or procedure without prejudice to my care.

Neither I, nor any member of my family, will be identified by name in any form of publication. Wherever possible, the photos will be cropped so as to show only the pertinent information, but not personally identifying information. I understand that in some circumstances, the photographs may portray features that will make my identity recognizable.

I have entered into this agreement in order to assist scientific treatment, educational, public relations and/or charitable goals and herby waive any right for compensation for these uses. I and my successors and assignees hereby waive any right for compensation for these uses. I and my successors and assignees hereby hold Michael J. Orseck, MD or Shawn A. Birchenough, MD, his employees, and any other person participating in my case and their successors and assignees harmless against any claim for injury or compensations resulting from the activities authorized by this consent.

______________________	______________________	______________________
Patient Printed Name	Printed Witness Name	Date
Patient Signature	Witness Signature	Date

GENERAL CONSENT TO TREAT/
PATIENT AUTHORIZATION/ACKNOWLEDGEMENT OF BENEFITS RELEASE

The following are the conditions for services provided by the Medical Group of the Carolinas which is affiliated with Spartanburg Regional Health Services District, Inc. (District) for the patient whose name appears at the bottom of this page.

CONSENT FOR MEDICAL TREATMENT

I/we voluntarily consent to medical treatment and diagnostic procedures provided by Medical Group of the Carolinas and its associated physicians, clinicians and other personnel. I/we consent to the testing for infectious diseases, such as, but not limited to syphilis, AIDS, hepatitis and testing for drugs if deemed advisable by my physician. I/we am/are aware that the practice of medicine and surgery is not an exact science and I/we acknowledge that no guarantees have been made as to the result of treatments or examinations.

AUTHORIZATION FOR RELEASE OF INFORMATION

The practice and physicians are authorized to release any medical information required in the processing of applications or submission of information for financial coverage, discharge planning and further medical treatment. To include information referring to psychiatric care, sexual assault or tests for infectious diseases including AIDS/HIV for services provided during this visit. I/we also agree to the release of medical or other information about me to government federal or state regulatory agencies as required by law.

TELEPHONE AUTHORIZATIONS

You hereby grant permission and consent to us, our assignees, and third party collection agents: (1) to contact you by telephone at any telephone number associated with you, including wireless numbers: (2) to leave answering machine and voicemail messages for you, and include any such messages information required by law (including debt collection laws) and/or regarding amounts owed by you: (3) to send you test messages or emails using any email addresses you provide: (4) to use pre-recorded/artificial voice messages and/or an automatic dialing device (an "auto dialer") in connection with any communications made to you or related to your account.

ASSIGNMENT OF INSURANCE BENEFITS

I/we guarantee payment of all charges made for or on account of the patient and I/we assign our rights in any insurance benefits or other funding to the physician and the Medical Group of the Carolinas. I/we understand that I/we am/are responsible for any charges not covered by insurance or other forms of benefits. I/we understand the Medical Group of the Carolinas can obtain my/our credit report for review in collection of this debt. In the event that this account is placed with a collection agency or attorney for collection or collected following the SC Setoff Debt Collection Act, I/we shall pay all collections fees and costs, including reasonable attorney's fees. For Medicare beneficiaries: I/we have provided all necessary information for proper assignment of Medicare benefits.

WORKER'S COMPENSATION PATIENT RECORDS RELEASE AND AUTHORIZATION FORM

I understand that South Carolina and North Carolina Worker's Compensation law provides that written information which pertains directly to a workers' compensation claim must be provided by a healthcare facility/physician to the insurance carrier, the employer, the employee, their attorneys, or the applicable State Workers' Compensation Commission pursuant to the SC Code Ann § 42-15-95 and NC ST § 97-27. **I authorize Spartanburg Regional Healthcare System (SRHS) to provide copies of my medical records or to speak to duly authorized representatives of any of the above regarding my medical records, medical treatment, or condition.**

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I/we have received a copy of the Notice of Privacy Practices. The notice describes how my health information may be used or disclosed. I understand that I should read it carefully. I am aware that the Notice may be changed at any time. The Notice of Privacy Practices may be accessed at www.srhs.com.

______________________ ______________________________________

Date and Time

Signature of Patient/(Relationship to Patient)

(Parent, Guardian or Legally Authorized Representative)

______________________ ______________________________________

Hospital Witness

Signature of Guarantor (Relationship to Patient)

Thank You For Choosing Spartanburg Regional For Your Healthcare Needs