Conway Physicians CONWAY PHYSICIANS GROUP PATIENT DEMOGRAPHICS					DATE	:	
Cloup	F	PATIENT INFOR	MATION				
Patient Name			DOB		Age		k Gender: MF
Address		Home Phone		Cell Phone			
City/State/Zip		SS#		E-Mail			
Race Religion		Highest Level of Education		Ethnicity Preferred Language			
Emergency Contact		Relationship		Emergency Phone #			
Pharmacy		Primary Care Provider Name					
	PATIENT	EMPLOYMEN	INFORM	IATION			
Employer Work Number GUARANTOR INSURANCE INFORMATION							
				MATION			
Primary Insurance	Primary Insura Employer		nformation_	Policy #		Group #	
Insured Name	Address		City/State/Zip			Insured DOB	Insured SS#
	Sec	condary Insurance	Information	า			
Secondary Insurance	Employer		Policy #		Group #		
Insured Name	Address		City/State/Zip		Insured DOB	Insured SS#	
REFERRAL INFORMATION							
How did you hear about us?							
CONSE	NT FOR HEALTH	CARE & RELEAS	SE OF MEI	DICAL INFO	RMATION		
I voluntarily consent to treatment at this facility by its p practice. I consent to the use and disclosure of my p	protected health in		atment, pa				
		LLATION & NO					
Recognizing that everyone's time is valuable and the Conway Physicians Group reserves the right to charge within a 24 hour adva	a fee of \$25.00 for	each missed (No	Show) appo	intment, whic	ch is, absent fo	or a compelling re	
	IAL RESPONSIBI						
I authorize Conway Physicians Group to bill my insuran for the unpaid charges for certain physician services to payments. I certify that the information given by m information about me to be released to the Social Secu	o Conway Physician e in applying for pa	ns Group. I under ayment under Titl n or its intermedia	stand that I e XVIII of th aries or carr	am respondib e Social Securi iers and any ir	ole for any hea ity Act is corre nformation ne	alth insurance de ect. I authorize a	ductible and co-insurance ny medical or any other

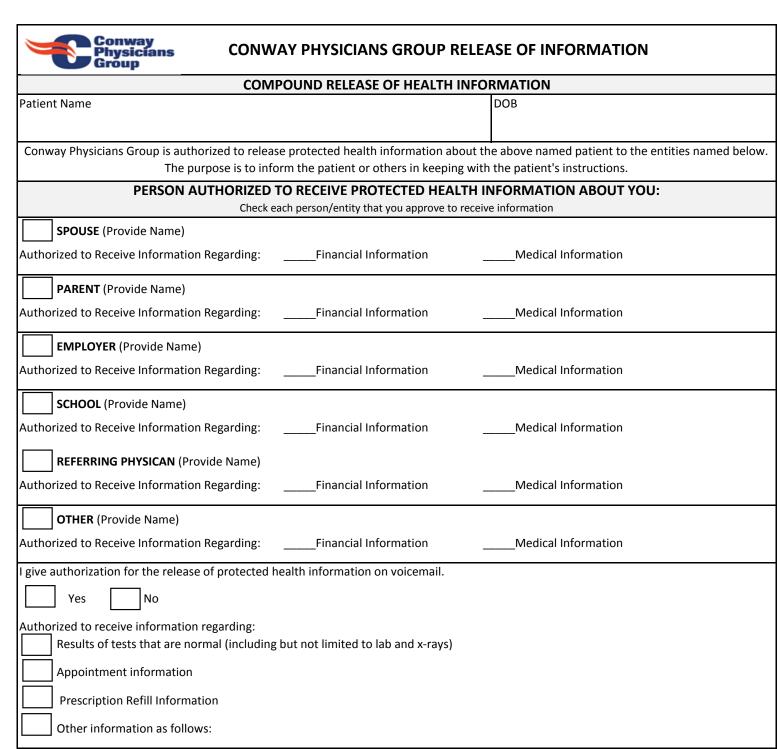
SURESCRIPTS & HEALTH INFORMATION EXCHANGE AUTHORIZATION

In accordance with SC State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that Conway Physicians Group uses Commonwell, an organization Cross-vendor interoperability is necessary to improve health care delivery and outcomes as well as SureScripts, INC., a prescription system that allows prescriptions to be exchanged between my providers and pharmacy. The information sent between these systems may include details of any and all prescription drugs I am currrently taking and/or have taken in the past. This authorization may include disclosure related to alcohol and drug abuse, mental health, or HIV related treatment. I have the right to revoke this authorization at any time. This authorization is voluntary and does not authorize Conway Physicians Group to discuss my health information or medical care with anyone other than those permitted under applicable law.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Privacy Practices are locted in the main lobby for review and may be offered a copy at my request. I am aware that the notice may be changed at any time and that I may request a copy of the revised notice by contacting Conway Physicians Group administration.

SIGNATURE OF AUTHORIZED PERSON:	DATE:



RIGHTS OF THE PATIENT

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending a written notification to Conway Physicians Group. I understand that a revocation is not effective in cases where the information has already been 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.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.

SIGNATURE OF AUTHORIZED PERSON:	DATE: