**Magnolia Plastic Surgery –Spartanburg**
The Doctors Center
391 Serpentine Dr STE 250
Spartanburg SC 29303
***Michael J. Orseck, MD***

**Magnolia Plastic Surgery- Five Forks**
Pelham Medical Offices at Five Forks
2801 Woodruff Rd STE 202
Simpsonville SC 29681
***Shawn A. Birchenough, MD***

**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: _____

**Emergency Contacts**

#1: Name: _____ Relationship: _____ Phone: _____

#2: Name: _____ Relationship: _____ Phone: _____

**[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 Michael J. Orseck, MD : 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

Medical Group of the Carolinas
A Division of Spartanburg Regional Healthcare System

## 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: _____

Medical Group of the Carolinas
A Division of Spartanburg Regional Healthcare System

# 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 | | YES | NO | |
|---|---|---|---|---|---|
| ☐ | ☐ | abnormal bleeding | ☐ | ☐ | hernia |
| ☐ | ☐ | blood clots | ☐ | ☐ | high blood pressure |
| ☐ | ☐ | breast implants | ☐ | ☐ | high cholesterol |
| ☐ | ☐ | cancer | ☐ | ☐ | kidney disease |
| ☐ | ☐ | COPD | ☐ | ☐ | lung disease |
| ☐ | ☐ | diabetes | ☐ | ☐ | psychiatric disease |
| ☐ | ☐ | emphysema | ☐ | ☐ | renal disease |
| ☐ | ☐ | epilepsy or seizures | ☐ | ☐ | stroke |
| ☐ | ☐ | heart attack | | | |
| ☐ | ☐ | heart disease | | | |

**List all operations, date and hospital:**

| YEAR | OPERATION | HOSPITAL |
|---|---|---|
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**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) |
|---|---|
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**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 |
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# Photographic Authorization and Release

By my signature below, I authorize my physician at Magnolia Plastic Surgery (Dr. Michael Orseck, 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 agree that my surgeon can share them with staff, other health professionals, and the public. This may be done for educational or marketing purposes. I understand that once my images are published, I lose control over their use. I have no control over where they are published. I agree to give up certain rights to my image. I release any claim I may have to the publication of such images. This includes any payment for their distribution.

I understand that images posted online may be saved. They may be available forever. They may be found in online searches. I realize that people may repost my images without my surgeon's consent. This may be used in social media. Neither I nor my surgeon have any control over this. I agree that my surgeon is not responsible for third-party use. I release my surgeon from any claim that might arise from this use.

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 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 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 |

# SPARTANBURG
**Regional Healthcare System**

☐SMC ☐PMC ☐UMC ☐CMC ☐MGC

## Outpatient Communications and Authorizations

Patient Name_____DOB:_____

***Permission to Release Information Regarding Medical Care***
***THESE ELECTIONS WILL BE IN EFFECT FOR ALL LOCATIONS***

☐ **I WANT** to designate a family member or other individual with whom my healthcare team may discuss information about my care.

Name: _____Relationship: _____ DOB: _____

Name _____ Relationship: _____ DOB: _____

*NOTE: This designation does not give the above-named individuals the right to make healthcare decisions for you, or access copies of your medical information. If at any time you are unable to consent to treatment or care, we will follow the procedure set forth in the South Carolina Adult Health Care Consent Act.*

☐ **I DO NOT WANT** to designate a family member or other individual with whom my healthcare team may discuss information about my care **BUT** in the event of an emergency, you may contact my emergency contact below.

Name: _____Relationship: _____ Phone: _____

*NOTE: This designation does not give the above-named individuals the right to make healthcare decisions for you, or access copies of your medical information. If at any time you are unable to consent to treatment or care, we will follow the procedure set forth in the South Carolina Adult Health Care Consent Act.*

☐ **I WANT** to designate a family member or other individual who is authorized to pick up any written prescriptions or medication samples on my behalf.

Name: _____Relationship: _____ DOB: _____

Name _____ Relationship: _____ DOB: _____

**I CONSENT** to my healthcare team leaving voicemail messages concerning treatment, payment, and/or other information pertinent to my care on the phone number(s) currently on file **[ ]** Yes **[ ]** No

**For Minor Patients**

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

Name: _____Relationship:_____Phone:_____

Name: _____Relationship:_____Phone:_____

***PLEASE SIGN AND DATE BELOW***

**PATIENT/GUARDIAN SIGNATURE** _____ **DATE** _____

***Thank You for Choosing Spartanburg Regional Healthcare System for Your Healthcare Needs***

Patient Label

**SPARTANBURG**
**Regional Healthcare System**

☐ SMC ☐ SHRC ☐ PMC ☐ UMC ☐ CMC
☐ MGC _____

# GENERAL CONSENT TO TREAT/PATIENT AUTHORIZATION ACKNOWLEDGEMENT OF BENEFIT RELEASE

The following are the conditions for services provided by the Spartanburg Regional Health Services District, Inc. (SRHS) 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 Spartanburg Regional Health Services District, Inc. and its associated hospitals, 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 hospital, practice, and attending physician 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. This includes 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.

**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 SRHS. I/we understand that such charges are liquidated damages not subject to dispute; that SRHS expects full payment, and that the acceptance of partial payment does not waive SRHS' right to collect full payment even if there is contrary language accompanying partial payment.

I/we understand that I/we am/are responsible for any charges not covered by insurance or other forms of benefits. I/we understand SRHS 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 collection fees and costs, including reasonable attorney's fees. For Medicare beneficiaries: I/we have provided all necessary information for proper assignment of Medicare benefits. I/we hereby grant permission and consent to SRHS, our assignees, and third party collections agents: (1) to contact me by telephone at any telephone number associated with me, including wireless numbers; (2) to leave answering machine and voicemail messages for me, and include in any such messages information required by law (including debt collection laws) and/or regarding amounts owed by me; (3) to send me text messages or emails using any email address I provide; (4) to use pre-recorded/artificial voice message and/or an automatic dialing device (an 'auto dialer') in connection with any communications made to me or related to my account.

**PHOTO/VIDEO/TELEVISING**
I/we consent to photographs, televising and/or videotaping for identification, diagnosis and/or treatment purposes. I/we consent to video monitoring in patient care areas for clinical care and safety reasons.

**VALUABLES RELEASE FOR HOSPITAL PATIENTS**
I/we have been requested to check valuables with the hospital and release the healthcare system of any liability and assume responsibility for any items not deposited to the hospital's care. Any valuables not claimed within thirty (30) days of discharge will become the property of the hospital.

**ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES**
I/we have received a (printed or electronic) copy of the Notice of Privacy Practices (NPP) prior to or at my first visit anywhere within SRHS. I also understand that the NPP is posted in all SRHS locations and may also be accessed at www.spartanburgregional.com. The NPP describes how my health information may be used or disclosed. I understand that I should read it carefully. I am aware that the NPP may be changed from time to time.

**INDEPENDENT STATUS OF PHYSICIANS**
I understand and agree that some of the practitioners furnishing services to me/the patient, such as radiologists, pathologists, and anesthesiologists may be independent contractors and not employees or agents of the healthcare system. These independent contracted practitioners, not the healthcare system, are responsible for their own acts or omissions. These independent contracted practitioners who render professional services to me/the patient may bill and collect separately from the healthcare system. Furthermore, I/we understand that each healthcare provider may be individually contracted with an HMO or PPO. The contracts could be different from the contracts the healthcare system holds. I/we understand that I/we need to find out if each healthcare provider is a member of my/the patient's insurance provider network.

_____ Patient Date of Birth

_____ Patient Name

_____ Date and Time

_____ Signature of Patient/Parent/Guardian/Legally Authorized Representative (Relationship to Patient)

Patient Label