W. Preston Turner, M.D.
Pete Parramore, M.D.
Arnold P. Mulkey, Jr. M.D.
Claudia E. King, Administrator

GU GREENWOOD UROLOGICAL

Adult and Pediatric Urology
Stone Diseases and Lithotripsy
Fertility-Sexual Dysfunction
Urological Oncology

We welcome you as a patient of Greenwood Urological. Enclosed you will find a brochure which tells you about our practice. We hope that you will read it and keep it on hand as a reference.

Please contact us at least 24 hours in advance if you cannot keep your appointment. Thank you

PLEASE COMPLETE THE ENCLOSED FORMS AND BRING THEM WITH YOU TO YOUR APPOINTMENT. ARRIVE 15 MINUTES PRIOR TO YOUR SCHEDULED APPOINTMENT TIME. This will expedite the registration process.

Please bring your insurance card(s) so that we may scan them into our computer. Also bring a list of any medication(s) you may be currently taking. If you do not have a list, please bring your medications. You will be asked to leave a urine specimen at the time of your appointment.

We expect payment at the time of service unless other arrangements have been made. Please ask our staff to confirm if we participate with your insurance plan. For these plans you will be responsible for the co-insurance, co-pay, and/or deductible portions of your bill. Please provide proof that you have met your deductible or we will look for you to pay the full allowed amount of your visit.

Our office is located at 109 Liner Drive in the Greenwood Professional Park. A map can be found on the back of the patient brochure. We look forward to seeing you and will be glad to answer any questions you have prior to your appointment. **Thank you for allowing us to participate in your medical care.**

CHART # ______________________

LOCATION ______________________

DATE ______________________

FAMILY PHYSICIAN ______________________

PATIENT INFORMATION

SOCIAL SECURITY # ______________________

PATIENT'S NAME ______________________ FIRST ______ MI ______ LAST ______

MAILING ADDRESS ______________________ CITY ______ STATE ______ ZIP CODE ______

STREET ADDRESS ______________________ CITY ______ STATE ______ ZIP CODE ______

HOME PHONE (   ) ______________ BIRTH DATE _____/_____/_____ SEX: MALE FEMALE

CELL PHONE ______________________

AGE __________ MARITAL STATUS: Single Married Widowed Widower Divorced Separated

EMPLOYMENT STATUS: Full-Time Part-Time Retired Student Not Employed Child (Complete Box Below)

IF EMPLOYED, WORK PHONE (   ) ______________ EMPLOYER ______________

EMPLOYERS ADDRESS ______________________

IF RETIRED, DATE OF RETIREMENT _____/_____/_____ SPOUSE'S NAME ______________

PHARMACY USED ______________ PHONE # (   ) ______________

IN EMERGENCY NOTIFY ______________ PHONE # (   ) ______________

RELATIONSHIP ______________ PLEASE GIVE A DIFFERENT PHONE NUMBER THAN YOUR OWN

INSURANCE INFORMATION

INSURANCE CARRIER: ______________________ CARD ATTACHED: YES NO

CARD SCANNED: YES NO

If Patient's Insurance Coverage is NOT THROUGH THEIR EMPLOYER or **IF Patient is a Minor,** PLEASE COMPLETE this box using accurate information for the Person Financially responsible for the account:

SOCIAL SECURITY # ______________ RELATIONSHIP TO PATIENT ______________

NAME ______________________ FIRST ______ MI ______ LAST ______

MAILING ADDRESS ______________________ CITY ______ STATE ______ ZIP CODE ______
(if different from the patient)

____

HOME PHONE (   ) ______________ BIRTH DATE _____/_____/_____ SEX: MALE FEMALE

INSURANCE COMPANY: ______________ EMPLOYER: ______________

EMPLOYER'S ADDRESS: ______________ EMPLOYER'S PHONE #: ______________

PLEASE COMPLETE INFORMATION ON THE OTHER SIDE

AUTHORIZATION, RELEASE, AND FINANCIAL POLICY

PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY, THEN SIGN AND DATE AT THE BOTTOM:

I consent to treatment necessary for the care of the patient named on this form.

I have received information regarding the providers of care in this organization, a copy of the Patient's Bill of Rights and Responsibilities, and information regarding the grievance process.

I authorize release of my medical records to Greenwood Urological Associates, P.A. (GU), to my family physician, to any other physician needed for my care, and to my insurance company, if required.

I understand that this organization does not recognize DO NOT RESUSCITATE orders or Living Wills in the office.

I authorize and assign payment of medical benefits by my insurance carrier to GU for any services furnished to me, and if received by me, I assign payment to GU upon receipt.

I understand that any co-pay required by my insurance company must be paid at the time of service and can not be billed to me.

I understand that I am financially responsible for the services provided to me, regardless of insurance coverage, and that full payment is expected at the time services are rendered to me.

I will be in default on payment of the amount due if it is not paid on the date service is rendered; however, GU reserves the right to defer reference of the default to collection proceedings depending on when and the amount of payments made, at GU's sole discretion. No other agreement is valid unless such other written financial arrangements have been signed by GU and me.

I agree, whether I have signed as agent or as patient that in exchange for the services to be rendered to that patient, I individually obligate myself to pay the account in full when services are rendered.

If this account is placed in the hands of an attorney for collection, by suit or otherwise, I agree to be responsible for and to pay all costs of collection and litigation (including court costs and statutory prejudgment interest) together with a reasonable attorney's fee.

Our NOTICE OF PRIVACY PRACTICES describes in detail how your health information may be used and disclosed, and how you can access your information. Please contact Claudia King, Compliance Officer, for any questions regarding this document.

I HAVE READ AND FULLY UNDERSTAND THE ABOVE CONSENT FOR TREATMENT RELEASE OF MEDICAL INFORMATION, INSURANCE AUTHORIZATION, AND MY FINANCIAL OBLIGATION.

______________________ DATE

______________________ PATIENT/RESPONSIBLE PARTY

W. Preston Turner, M.D. | GU GREENWOOD UROLOGICAL | Pete Parramore, M.D.

MRN: _______________ **DOB:**_______________

Patient Name: ____ **Date:** _______________

Medical Doctor/PCP: ____

Who referred you: ____

Why are you here today? ____

Allergies: *Please list all allergies*

Penicillin Sulfa Drugs Codeine Cipro Mycins

Others: ____

Medications: *Please list all medications including Dosage and Instructions*

____

____

____

____

Primary Pharmacy Preference: (*Name & Number*) ____

Surgical History: (Circle all that Apply)

Cystoscopy	Appendix	Hernia Repair	Other Surgeries:
Bladder Surgery	Defibrillator	Hip Surgery	____________
Kidney Stone Surgery	Gallbladder	Hysterectomy	____________
Lithotripsy	Heart Bypass	Joint Replacement	____________
Prostate Biopsy	Heart Stent	Knee Surgery	____________
Prostate Surgery	Heart Valve	Lumbar Disc	____________
		Pacemaker	____________

Medical Problems: (Circle all that Apply)

Bladder Cancer	Anxiety	Endometriosis	Stroke
UTI's	Atrial Fibrillation	GERD	Cancer: ____________
Elevated PSA	Congestive Heart Failure	Heart Attack	
Enlarged Prostate	Depression	High Blood Pressure	Other Medical Problems: ______
Kidney Cancer	Hepatitis	High Cholesterol	____________
Kidney Stones	Diabetes	HIV	____________
Prostate Cancer	Diverticulitis	Kidney Failure	____________
Blood in Urine	Emphysema	Mitral Valve Prolapse	____________

Family History: (Circle all that Apply)

Kidney Cancer	Anesthesia Reactions
Kidney Stones	Bleeding Disorder
Prostate Cancer	Sickle Cell Anemia

Social History: (Circle all that Apply)

Status: Single Married Widow Divorced Other

Tobacco Use: Current — If Current: Type: ____________ Packs per Day: ____________
Former — How many years ago did you quit: ________
Never

Alcohol Use: Current — Daily Intake: ____________________
Former — How many years ago did you quit: ________
Never

Employer: ____

Please continue on back side

W. Preston Turner, M.D. GU GREENWOOD UROLOGICAL Pete Parramore, M.D.

Language: ______________________

Race: ______________________

Ethnicity: Hispanic or Latino or ______________ Not Hispanic or Latino

Review of Systems: (Circle all that Apply)

Constitutional:	Fever	Weight Loss	Weight Gain
Eyes/Nose/Throat:	Glaucoma	Sinus/Nasal Congestion	Cataracts
Cardiovascular:	Chest Pains	Swelling of Ankles	Shortness of Breath with exertion
Respiratory:	Shortness of Breath	Wheezing	Cough
Gastrointestinal:	Constipation	Acid Reflux	Diarrhea
Genitourinary:	Incontinence/Leakage	Blood In Urine	Getting up at night to urinate
Musculoskeletal:	Back Pain	New Bony Pain	History of Broken Bones
Integumentary/Skin:	Rash	Persistent Itching	Easy Bruising
Neurological:	Seizures	Headaches	Tremors
Hematologic/Lymphatic:	Swollen Lymph Glands	Abnormal Bleeding	Blood Clots in Legs
Infections/Diseases:	HIV	Hepatitis	STD's
Gynecological:	Ovarian Cyst	Endometriosis	Vaginal Discharge

Patient Signature: ______________________

Physician Notes:

Physician Signature: ______________________

Reviewed by Assistant: ______________________

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION
Greenwood Urological

Patient Name ________________________________

Social Security # ________________________________

Date Of Birth ________________________________

This authorization to release medical information is being requested of you in compliance with the general terms of the confidentiality of medical information.

By my signature below, I authorize you to discuss or release all information, including medical records, x-rays, history, and findings and prognosis pertaining to my medical condition, services rendered me, or treatment given me to:

____

This authorization shall remain in effect for one year or until canceled in writing.

____

Signature of patient/parent/conservator/guardian/ or patient's representative

____
Date

DNKA POLICY

The policy states that patients who do not cancel appointments 24 hours ahead will be charged $25.00.

New patients appointments not cancelled 24 hours ahead will be charged $50.00.

$100.00 will be charged to patients who do not cancel their procedure appointments 48 hours ahead.

Patients referred by the Emergency Department will be considered on a case-by-case basis.

These charges should be paid before the patient will be seen.

This policy will be incorporated in our financial agreement.

If the patient does not keep his\her appointments three times, he\she will be fired from the practice.

Please sign below that you have read the above policy:

______________________________ ____________________

Patient Date

Policy effective date: 3/01/2003

____________Greenwood Urological________________

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGE

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting Claudia King, Administrator.

Our NOTICE OF PRIVACY PRACTICES describes in more detail how your health information may be used and disclosed, and how you can access your information.

By my signature below, I acknowledge receipt of the NOTICE OF PRIVACY PRACTICES.

______________________ Patient or legally authorized Individual signature	______________________ Date Time
______________________ Printed name if signed on Behalf of the patient	______________________ Relationship

Disclosure Information

To Our Patients:

Welcome to the practice, which is owned by Dr. W. Preston Turner and Dr. Herman (Pete) Parramore.

Your Surgeon/Physician: We would like you to know that Dr. W. Preston Turner is board certified by the American Board of Urology and is licensed in the State of South Carolina. He has been in practice since 1985 and attended Wofford College, the Medical University of S.C., Greenville Memorial Hospital and the University of Louisville. You may request his C.V. which we keep on file. His training is extensive in the field of urology. Our other physician, Dr. Herman (Pete) Parramore, is also board certified by the American Board of Urology and is licensed in the State of South Carolina. He has been in practice since 1995 and attended Abraham Baldwin College, the University of Georgia, the Medical College of Georgia, the University of Kentucky, and the University of Florida. You may request his C.V. which we have on file. His training is extensive in the field of urology. Should you choose to have surgery at this organization, Dr. Turner or Dr. Parramore will perform the surgery.

The Team: Our team is made up of competent individuals that will assist in providing safe patient care.

Should you have a problem: Please be advised that if you have a grievance or concern the following mechanism exists: Ask for the grievance form from the receptionist. Or you may call the accrediting organization that oversees our compliance with standards of care The Joint Commission on Accreditation of Healthcare Organizations at 800-994-6610 or emailing complaint@jcaho.org. OR The Accreditation Association for Ambulatory Health Care, Inc at 847- 853-6060/

Make a suggestion: If you have a suggestion, please place this is writing and hand to the receptionist or mail it to the office.

Play a part in your care: We encourage all patients to be actively involved in their care, so please speak up and ask questions of anyone in this organization.

Additionally, please be advised that this organization does not recognize Do Not Resuscitate orders or Living Wills while you are in our office. If you have any questions, please see the receptionist.

Infection Control: This practice educates staff upon hire and annually thereafter in hand hygiene and we follow the CDC guidelines for hand hygiene. We encourage staff to stay home when they are sick. We provide tissues and garbage cans throughout the facility and encourage everyone to cover their mouth when coughing or sneezing and then wash their hands.

PATIENT ACKNOWLEDGEMENT OF DISCLOSURE INFORMATION

My signature below acknowledges the following:

- I have received a copy/am aware of the **Patient Bill of Rights**; as required by law and have had an opportunity to receive assistance in understanding and exercising these rights.
- I have received a copy/am aware of this office's **Notice of Privacy Practices**, including the **Private Health Information (PHI)** designated at the time of visit.
- I have received information on/am aware of the **Speak Up Program** Campaign.
- I have received information on/am aware of the Infection Control measures utilized by this organization.
- I have received information on/am aware of the safety measures taken by this organization when a procedure is planned.
- I have received a copy/am aware of the **Practice Disclosure (about our Practice, including the Grievance process)** and am comfortable with that information. I also understand this practices position on **Do Not Resuscitate (DNR) and Living Wills** and that this practice does not honor these directives.

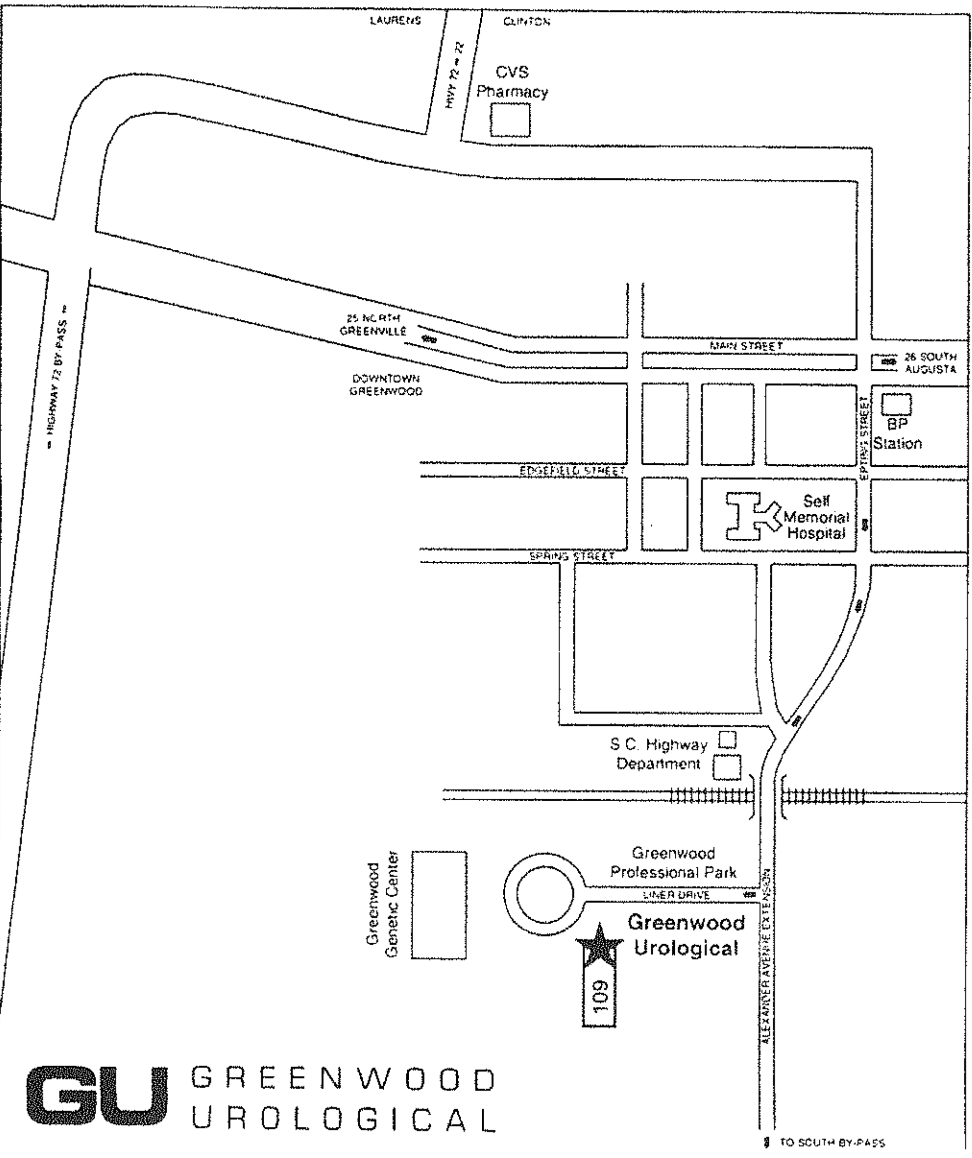
Signature of Patient/Representative________________________________Date__________

Above signature was not obtained because:

☐ Patient is unable and unaccompanied by a representative. Patient left with all pertinent disclosures.

☐ Patient refused to sign.

☐ Patient refused forms.



GU GREENWOOD UROLOGICAL

109 Liner Drive
Professional Park
Greenwood, SC 29646

(864) 227-6401
1-800-922-4194

WELCOME

We would like to welcome you as a patient of Greenwood Urological, P.A. We appreciate this opportunity to provide you with medical services. The information that follows should answer many of your questions concerning our policies and methods of practice. However, if there are any questions that are not covered, please do not hesitate to ask.

Everyone in this practice operates as a team member and we take pride in our professional capabilities. Thank you for allowing us to participate in your urological care.

UROLOGY SERVICES

Urology is a specialty of medicine that deals with diseases and disorders of the urinary and reproductive systems in the male and of the urinary tract in the female. Kidney stones, urinary tract infections, incontinence, male impotence and infertility, prostate problems, and cancers of the kidney, testicles, and bladder are examples of the conditions we treat. Our urology practice includes the diagnosis and management of diseases as well as the performance of surgical procedures upon those organs that make up the urinary tract and the male reproductive system.

APPOINTMENTS

We see our patients by appointment only. We will see you as promptly as possible, as we realize that your time is valuable. Occasional waiting beyond the scheduled appointment time may be necessary for the handling of emergencies or other unforeseen circumstances. You will be informed if there will be a delay and given the option of rescheduling your appointment.

If you are unable to keep an appointment, please notify us at least 24 hours in advance. Also, please remember that if you are late 15 minutes or more for your appointment, it may have to be rescheduled for another time.

Before bringing in any post-vasectomy specimen, please call the office to make sure a doctor will be available to check it in a timely manner.

HELPFUL HINTS FOR EACH VISIT:

1. Please sign the register before being seated.
2. **Be prepared to leave a urine specimen.**
3. If a family member would like to see the doctor with you, they should come with you when you are called back.
4. Please let our receptionist know if any of your key information has changed since your last visit.
5. **Please bring your current medications with you on your first visit.**

Typically, only one family member is allowed to go back with the patient to be seen by the physician. However, there may be occasions that NO family member will be allowed in the exam rooms due to limited space or complex procedures. This will be determined by our nursing staff.

WEBSITE

Please visit our website at: www.greenwoodurological.com.

SATELLITE OFFICES

For the convenience of our patients, we have opened several satellite offices. Please ask our staff for additional information.

THANK YOU

We at Greenwood Urological hope that this will be a helpful tool in making your visits with us as comfortable and as pleasant as possible. We appreciate the opportunity to work with you to provide the finest medical care possible.

CONFIDENTIALITY

All medical records are kept strictly confidential and private.
No information regarding your condition will be given to employers, friends, or relatives without your written permission unless it is required by law.

GRIEVANCE PROCESS

Our front office has grievance forms that can be completed and returned in person or by mail.

DOCTOR - PATIENT RELATIONS

A urologist is a doctor of medicine (M.D.) who is trained and licensed to practice medicine and surgery. Our doctors and staff make a special effort to explain everything to you regarding your condition, medicine, and treatment options. If you ever have any questions or something is not clear to you, do not hesitate to ask.

Dr. Preston Turner

Dr. Turner, a native of Greenwood, joined Greenwood Urological in 1991, after several years in private practice in Mt. Vernon, Washington. Dr. Turner graduated from Wofford College and the Medical University of SC. He completed a surgical internship at Greenville Memorial Hospital and his Urology residency at the University of Louisville. He is certified by the American Board of Urology. Dr. Turner and his wife, Callie, have 3 children.

Dr. Pete Parramore

Dr. Parramore joined Greenwood Urological in 1995. He is originally from Tifton, Georgia and graduated from the University of Georgia. Dr. Parramore received his M.D. degree from the Medical College of Georgia and then completed his internship in Surgery at the University of Kentucky in Lexington. He completed his Urology residency at the University of Florida in Gainsville and he is certified by the American Board of Urology. Dr. Parramore and his wife, Natalie, have 3 children.

Claudia King

Claudia joined Greenwood Urological as the Practice Administrator in January 2000. She is a graduate of the S.C. Baptist Hospital School of Radiologic Technology and attended Limestone College. She has had past experience as the Clinic Manager of two urgent care centers in the Rock Hill/Charlotte area and as the Director of Physician Services for the Laurens County Health Care System. It is Claudia's responsibility to see that you are provided with excellent service from our staff. Please feel free to contact her with any problem or suggestion you might have as to how we can better meet your expectations.

X-RAY SERVICES AND PROCEDURES

We are happy to be able to provide a number of specialized services at our offices. Routine cystoscopy is performed in our office. X-ray services are provided in addition to urodynamic studies, ultrasound and vasectomy. You may be given special instructions to follow before you arrive for an x-ray or other office procedure.

TELEPHONE CALLS

The person answering the telephone in our office is a member of our practice team. We can most effectively handle your call if you give this individual complete and accurate information. Our business office staff can handle almost all questions related to billing, insurance, or appointments. Medically related calls will be directed to one of our clinical staff. They will return your call as soon as possible and will consult with one of the doctors if necessary.

By following the suggestions listed below, you will speed up the handling of your message:

1. Please make the call yourself.
2. Please give your full name and your doctor's name.
3. Be very specific as to the question that you want answered.
4. Leave a phone number and times when you can be reached if you must talk with the doctor.

All patients are encouraged to call with any questions they have regarding medical problems; however, it would be most unfair to other patients were the doctor to leave the exam room to answer every phone call. The office staff has been trained to answer many of your questions and can also relay your information to the physicians.

PRESCRIPTIONS AND REFILLS

Please request any necessary prescriptions during your scheduled appointment. Prescription refills, especially those for PAIN MEDICATION, will ONLY be issued between the hours of 9 AM and 4 PM, Monday through Friday. Please have your medications and pharmacy telephone number readily available when you call.

EMERGENCY CARE

We recognize that you can have an emergency arise at anytime and we will do our best to respond promptly. Emergencies arising during regular office hours should be reported to our office at 864-227-6401 or 1-800-922-4194.

Emergencies arising before or after office hours, on weekends, or during holidays should be handled by calling Self Regional Healthcare in Greenwood at 864-725-4111. The Hospital Operator will put you in contact with the physician on call. PLEASE call and talk to the physician on call before going to the Emergency Room if at all possible.

REMEMBER THIS IS FOR EMERGENCIES ONLY!

FEES

We share your concern about the increasing cost of providing medical care. Our fees are based on the quality of service and are in line with the usual and customary charges for this area. If you have any questions regarding our fees, the office management team will be happy to discuss them with you.

BILLING AND COLLECTION

Payment is expected at the time services are rendered. We accept cash, checks, debit cards, Visa, MasterCard, American Express and Discover. Paying at the time of service helps reduce the costs associated with billing and keeps our overhead down without diminishing the quality of our services.

If you have met your deductible for a plan in which we are a participating provider, please bring your most recent Explanation of Benefits with you, so that we may correctly calculate the amount due. **ALL** co-pays must be paid at the time of service.

Please do not let financial problems prevent you from getting necessary medical care. If you have any problems in meeting your obligation, please discuss this honestly with us as soon as possible and we will do all we can to work out a plan for you. Should an account become past due without reason or explanation from you, collection procedures will begin 90 days from the initial billing date.

For billing and collection questions, please call our toll free number, 888-482-4869.

MEDICATE PATIENTS

We are participating providers in the Medicare and some Medicare Advantage Programs. If you are not sure of your coverage, please contact our office before you are seen. You will be responsible for payment of the Medicare deductible and co-insurance as well as any non-covered services.

PRIVATE INSURANCE

We will ask you to complete a patient registration form and sign an authorization that will allow us to release information to your insurance company for reimbursement. Please be sure to provide us with your current insurance card so we can be sure to have the correct information on file. We are participating physicians with numerous managed care companies.

As a courtesy, we will submit claims to your insurance carrier.

Remember, the financial responsibility for services rendered is the direct responsibility of the patient and/or his family regardless of any insurance coverage. Your medical insurance is a contract between you and your insurance company and we cannot guarantee payment of your claim. We will, of course, be happy to do what we can to help resolve any disputed claims. You should direct any questions or complaints regarding coverage to your employer or your insurance carrier.

DISABILITY FORMS

We will provide you with one standard disability form at no charge that can be attached to your carrier's form. If your company requires a specific disability form completed, the cost will be $25.00. FMLA (Family and Medical Leave Act) forms will cost $25.00 to be completed. Please be sure you complete the authorization to release information and sign the form before bringing it to us. We ask that you allow us one week to complete these forms. It is not our office's policy to place telephone calls to disability companies regarding patients who are out of work.

PRE-AUTHORIZATION OF DRUGS

We will charge $25.00 to complete pre-authorization drug forms.