Carolina Medical Consultants, PA **Patient Information/Consent to Treatment**

PATIENT INFORMATION

First Name:	M.I.:	Last Name:	Date of Birth:	Age:	Sex: M F
Street Address:		City:	State:		Zip Code:
E-Mail Address:		Primary Contact #:		Secondary Contact #:	
SSN:		Marital Status: Single Married Divorced Widowed			

CURRENT EMPLOYER

Employer Name:		Phone:	Ext:
Street Address:	City:	State:	Zip Code:

GUARANTOR INFORMATION

First Name:	M.I.:	Last Name:		Date of Birth:	Sex: M F
Street Address:	City:	State:	Zip Code:	Primary Contact #:	Secondary Contact #:
SSN:			Employer:		

EMERGENCY CONTACT

First Name:	M.I.:	Last Name:		Relationship to Patient:	Sex: M F
Street Address:	City:	State:	Zip Code:	Primary Contact #:	Secondary Contact #:

DEMOGRAPHICS

Please Circle Your Race: Black/African American Asian Hawaiian/Pacific Islander White Other

Please Circle Your Ethnicity: Hispanic/Latino Not Hispanic/Latino Other

Preferred Language: English Other:

PREFERRED PHARMACY

Primary Pharmacy Name:	Phone Number:
Pharmacy Address:	
Secondary Pharmacy Name:	Phone Number:
Pharmacy Address:	

Financial Responsibility and Assignment of Insurance Benefits:

I guarantee payment to Carolina Medical Consultants, PA for all charges for services provided to the patient. I understand I am personally responsible for all charges not covered by insurance. I authorize payment of medical benefits, which would otherwise be payable to me, to Carolina Medical Consultants, PA for services rendered. I understand that I must pay in full at time of service for all charges related to a motor vehicle accident. I understand that if I have no insurance coverage, payment in full is due at time of service. I covered by Medicare, I certify that the information provided by me in applying for payment under Titles V, XVIII and/or XIX of the Social Security Act is correct.

Consent for Healthcare and Release of Medical Information:

I voluntarily consent to healthcare treatment from the physicians and staff at Carolina Medical Consultants, PA. I am aware that the practice of medicine is not an exact science. No guarantees have been made to me regarding the result of treatments or examinations by my caregivers. I consent to the use and disclosure of protected health information about me for treatment, payment, and healthcare operations. I have read this form. I have had the opportunity to ask questions and my questions have been answered.

Signature of Patient or Authorized Person: ____ Date: ____________

Insured Party or Financial Guarantor if different from above: ____________________________________ Date: ____________

Acknowledgement of Receipt of Joint Notice of Privacy Practices:

I have received a copy of Carolina Medical Consultants, PA Notice of Privacy Practices. I am aware that the Notice may be changed at any time. I may obtain a revised copy of the Notice on our website at www.carolinamedical.us or by requesting one at our office.

Signature of Patient or Authorized Person: ____ Date: ____________

Carolina Medical Consultants, PA
311 Glenwood Drive
Rock Hill, SC 29732

Notice of Privacy Practices

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. This 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.

As a patient, you have the following rights:

1. The right to inspect and copy 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 communications;
5. The right to a report of disclosures or your information; and
6. The right to a paper copy of this Notice.

In the event a physician or medical facility requests my Protected Health Information for the purpose of continuation of care, I authorize Carolina Medical Consultants to release all medical records including information relating to drug, alcohol, psychiatric conditions, and/or sexually transmitted disease, including HIV/AIDS information. I agree to allow this practice to leave medical information on my answering machine when needed.

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

If you have any questions about this Notice, our contact information is listed on this page.

Termination Date of this Notice : Does not Terminate
Contact : Carolina Medical Consultants Employee
Contact Number: 803-366-7175

Acknowledgement of Notice of Privacy Practices

"I hereby acknowledge that I have received a copy of the practice's Notice of Privacy Practices. I understand that if I have questions or complaints regarding my privacy rights that I may contact this practice. I further understand that the practice will offer me updates to this Notice of Privacy Practices should it be amended, modified, or changed in any way."

____
Patient Name (please print)

____ _____________
Patient or Representative Signature Date

____ Patient refused to sign ____ Patient was unable to sign because ______________________.

CAROLINA MEDICAL CONSULTANTS, PA
FINANCIAL POLICY

It is our policy to provide quality care to our patients. We ask your cooperation by assisting us with our financial policy.

Contracted Insurances: We will file and accept assignment on all contracted insurances. We will file in a timely manner from the date of service. Patients are expected to pay co-payments and deductibles at time of service. Depending on the policy, services deemed non-covered or not medically necessary will be the patient's responsibility. Patients are responsible for presenting their current insurance card.

Medicare: We accept assignment for established patients, which means we will file all Medicare claims. The patient is responsible for deductibles, co-payments, and non-covered services.

Secondary Insurances: We will file to participating secondary insurances.

Workers' Comp: Authorization for Workers' Compensation must be received and verified prior to the appointment. If this is unavailable, you will be expected to pay in full at time of service.

Self-Pay: Payments are expected in full at time service unless other arrangements are made. Self-pay patients will be given a 25% discount if they pay in full at the visit.

Additional Information:

You will be charged an additional fee of $30.00 for any check returned to our office for non-payment.
Please have updated insurance and personal information ready at check-in.
You may request assistance with your outstanding balance by arranging an acceptable payment plan.
Our office requires a **24 hour notice** if you are unable to keep an appointment. We reserve the right to charge a fee if suitable notice is not given.
Missed appointments may result in no show fees of $15.00 to $45.00.
Patients are responsible for fees not covered by their insurance plans per their contracts.

I have read and understand these policies:

_______________________________________ ___________
Patient's or Guarantor's Signature Date

____
Patient's Printed Name

Carolina Medical Consultants, PA

311 Glenwood Drive
Rock Hill, SC 29732
Phone: 803-366-7175
Fax: 803-366-2099

Matthew D. Jenkins, MD
Rhea Hsu, MD
John C. Hoitink, MD
Randolph V. Villamor, MD
Sheryl Lamb, APRN

Authorization to Release Protected Health Information (PHI)

Date: ____________

Patient Name: _________________________ DOB: __________________

To authorize Carolina Medical Consultants, PA to release your medical records to you or someone other than yourself, such as another physician, a family member or friend, or insurance company, I will need to provide a written list of those persons below. This designation of care providers will be kept as a permanent part of my medical record and will be copied as required in order to allow communication of my PHI. I understand that my health care providers will use judgment in determining the minimum amount of information that must be shared in order to care for me. I also understand that I can revoke or add to any of the names on this list at any time as long as it is in writing.

I hereby authorize the release of my PHI from Carolina Medical Consultants, PA to the following persons, physicians, and/or organizations:

Name:	Phone Number(s): **REQUIRED**	Relationship:
______________________	________________________	_________________
______________________	________________________	_________________
______________________	________________________	_________________
______________________	________________________	_________________
______________________	________________________	_________________
______________________	________________________	_________________

I understand that as a part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to other physicians, laboratories, insurance companies, or other entities, in regards to my medical care and collection of payment for services rendered. I consent to such disclosure for these permitted uses, including disclosures via fax.

Signature: ____ Date: _________

Signer's Name if other than patient: ________________________ Relationship: __________