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

PATIENT INFORMATION – PLEASE COMPLETE ALL FIELDS!					
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- PLEASE COMPLETE ALL FIELDS					
Employer Name:			Phone:		Ext:
Street Address:	City:		State:		Zip Code:
GUARANTOR INFORMATION- PLEASE COMPLETE ALL FIELDS					
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 – PLEASE COMPLETE ALL FIELDS					
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 Financial Policy

Review the following financial policies of Carolina Medical Consultants. Payment is expected at the time of service. This applies to self-pay and copay amounts as determined by insurance companies which we are contracted with.

Contracted Insurance Company: The physicians of Carolina Medical Consultants have signed agreements with certain insurance companies. As a participating provider we agree to file and accept assignment on your claims to the insurance company. As the patient, you agree to provide us with the most up to date insurance card at the time of your visit. Failure to present a correct insurance card could result in a delay of filing your claim. If the patient does not present a valid insurance card for the visit, the date of service will become the patient's responsibility. The patient or guarantor also agrees to pay any copay amounts. If a procedure is deemed non-covered or not medically necessary by the insurance company, the charge amount is the patient's responsibility.

Medicare: Standard Medicare is filed for the patient and assignment is accepted. On standard Medicare there is a deductible and 20% copay the patient must pay each year. If the patient has a secondary insurance to Medicare our office will file it for you as long as we have the insurance card and information on file. The patient may be asked to sign an Advanced Beneficiary Notice Form at the time of visit. This form alerts Medicare patients that the procedure may not be covered by Medicare and as such will become the patient's responsibility to pay. Our office is not a preferred provider for any of the Medicare Advantage Plans.

Medicaid: Carolina Medical Consultants does not accept any new Medicaid patients, new or established.

Secondary Insurances: Carolina Medical Consultants will file to participating secondary insurances.

Self-Pay: Payment is expected in full at time of service. Self-pay patients will receive a 25% discount if the charge is paid in full at the visit. If not paid in full at the time of the visit, no discount will be offered later.

Workers' Compensation: Carolina Medical Consultants is not a preferred provider for Workers Compensation. Please notify your company of your injury and they will refer you to a covered provider.

Other Financial Information

Checks which are returned to Carolina Medical Consultants for insufficient funds or non-payment will result in a $30.00 returned check fee on the account. These checks may be turned over to the court system for recoupment.

A **payment plan option** is available in limited circumstances for established patients in good standing. Contact the billing department if you need this option. After review of your account a determination will be made whether to allow this option for you. Note: payment plans do not exceed 6 month.

Missed appointment/ Same day cancellation charge: The physicians at Carolina Medical Consultants ask if you are not able to keep an appointment to call our office to cancel. If you do not give a 24 hour notice which results in a missed scheduled appointment you may be charged from $15-$45, depending on the type of appointment. Repeated offenses may result in dismissal from the practice.

Copy of Medical Records: Carolina Medical Consultants uses an independent company to make copies of medical records the patient has requested to be sent to either another medical office or facility. Any charges related to this are billed separately by the company and usually require receipt of payment before the records are sent. If for some reason our office does this service in-house, the South Carolina mandated allowed charges are used to set any fees.

Patient'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
Denine Raymond, 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: __________

Immunization Registry Consent:

I give my consent for Carolina Medical Consultants, PA to release my immunization(s) and identifying information to the South Carolina State Immunization Registry. I understand the purpose of the Immunization Registry is to assist in my medical care and to record the immunizations that I have had or will receive in the future. My immunization information may potentially be used by the Department of Health for quality improvement purposes, epidemiologic research, and disease control purposes. Information used for quality improvement or any research purposes will have my personal identifying information removed.
The immunization information in the State Immunization Registry may be released to the following: myself, my health insurance organization, the state and local health departments, any school that I am registered to attend, and authorized medical providers that deliver my medical care.
I understand that there will be no effect on my treatment, payment, or enrollment for benefits if I choose not to participate in the State Immunization Registry. This consent may be withdrawn at any time by using the form provided. Information about immunizations received by the State Immunization Registry with my consent will remain in the State Immunization Registry if I later choose to withdraw my consent. However, future immunizations will not be recorded in the State Immunization Registry.

______________________________ ______________

Patient Signature Date

Electronic Prescription History Consent:

I agree that Carolina Medical Consultants, PA and it's providers and staff may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes**.**

______________________________ ______________

Patient Signature Date

☐ Check here to DECLINE the Electronic Prescription History consent. **Declining to sign this consent may result in certain medications not being filled by our office.**

Prescription Refill and Prior Authorization Policy:

All refill requests will be processed within 48 business hours of receipt of the request. Refill requests received on Fridays will be processed the following week.
Below are guidelines regarding refilling of medications and prior authorizations:

- Unless otherwise directed by your provider, maintenance medications such as Blood pressure, Diabetes, Cholesterol and Thyroid will only be approved if the patient has had an office visit within the last 3 months and a scheduled follow-up appointment.
- Narcotics, other controlled substances such as ADD/ADHD medication, and sleep aids will require a mandatory physician and/or nurse visit as directed by provider. We will not replace lost or stolen prescriptions for narcotics and controlled substances.
- Antibiotics will not be called in. An office visit is required for ALL antibiotic prescriptions.
- Any medication that requires a Prior Authorization may be changed to a covered prescription on your drug formulary. It is the patient's responsibility to provide us with their formulary. If a prior-authorization is deemed necessary, an additional office visit may be required.

Patient Signature: ______________________________ Date: ______________________

CAROLINA MEDICAL CONSULTANTS, PA **NAME: ____________________**
HEALTH HISTORY QUESTIONNAIRE **DOB: ___/____/___________**

Your answers on this form will help your health care provider better understand your medical concerns and conditions

Main reason for today's visit: ____

Other concerns: ____

How did you hear about us? ____

ALLERGIES

List anything that you are allergic to (medications, food, bee stings, etc.) and how each affects you.

ALLERGY	REACTION
1.	
2.	
3.	

FAVORITE PHARMACY: ____________________ Address and/or phone #: _________________________

Mailorder pharmacy if applicable: ____

MEDICATIONS

Please list all the medications you are taking. Include **prescribed drugs** and **over-the-counter drugs**, such as **vitamins, aspirin, herbals,** and **inhalers.**

DRUG NAME	STRENGTH	FREQUENCY TAKEN	FOR WHAT REASON?
1.			
2.			
3.			
4.			
5.			
6 .			
7.			
8.			
9.			
10.			
11.			
12.			

Additional Medication Information:

____

____

____

IMMUNIZATION HISTORY

Immunizations and most recent date:

Tdap (Tetanus and pertussis) Date:___________

Hepatitis B Date:__________________

Pneumonia Date:__________________

Hepatitis A Date:__________________

Chickenpox Date: ________________

Flu Shot Date:_________________

MMR (Measles, Mumps, Rubella) Date:________

Gardasil/HPV Date:__________________

Meningococcus Date :________________

Zostavax (Shingles) Date:__________________

Tetanus Date:__________________

Shingrix Date: _________________

(WOMEN ONLY) OBSTETRIC & GYN HISTORY

Last Pap Smear date: __________ Abnormal Y/N

Last Mammogram date: _________ Abnormal Y/N

Age of first menstrual period: _________

Date of last menstrual period or age of menopause: _________

Number of pregnancies? _____ births? ______

miscarriages? ______ abortions? ________

C-sections? __________

Are you experiencing any of the following?

❑bleeding between periods ❑painful intercourse

❑Heavy periods ❑Extreme menstrual pain

❑Vaginal itching, burning, or discharge

❑Breast lump ❑Nipple discharge ❑hot flashes

PAST MEDICAL HISTORY

Please check all that apply:

❑Abnormal Pap Smear
❑Atrial Fibrillation
❑Anxiety Disorder
❑Arthritis
❑Asthma
❑Bleeding Disorder
❑Blood Clots (or DVT)
❑Cancer: _____________
❑Coronary Artery Disease
❑Diabetes
❑Dialysis
❑Depression
❑Diverticulosis
❑Eye disorder:_____________
❑Fibromyalgia
❑Gout
❑Heart Attack
❑Heart Murmur
❑Hiatal Hernia or Reflux Disease
❑High Blood Pressure
❑High Cholesterol
❑HIV or AIDS
❑Kidney Stones
❑Kidney disease
❑Leg/Foot Ulcers
❑Liver Disease/Fatty Liver
❑Lupus
❑Osteoporosis
❑Pacemaker
❑Pulmonary Embolism
❑Reflux or Ulcers
❑Sleep Apnea/CPAP
❑Stroke
❑Tuberculosis
❑Thyroid problem
❑Other: ____
❑Other: ____
❑Other: ____
❑Other: ____

PAST SURGICAL HISTORY

SURGERY	REASON	YEAR	HOSPITAL/ SURGEON
1.______________________	______________________	______________	__________
2.______________________	______________________	______________	__________
3.______________________	______________________	______________	__________
4.______________________	______________________	______________	__________
5.______________________	______________________	______________	__________

PROCEDURAL/EXAM HISTORY:

If applicable, state the **most recent date** and **where** you have had any of the following.

	DATE	DOCTOR/FACILITY
Colonoscopy:	______________	______________________
Heart test (Stress test, ECHO, EKG):	______________	______________________
Bloodwork/Labs:	______________	______________________
Physical/Complete Medical Exam:	______________	______________________
Bone Density Scan/DEXA:	______________	______________________
Eye Exam:	______________	______________________

FAMILY HEALTH HISTORY: ****INCLUDE PARENTS, GRANDPARENTS, SIBLINGS, AND CHILDREN*****

DIAGNOSIS	WHO HAD IN FAMILY	AGE OF ONSET
Alcoholism	________________	___________
Anxiety/Depression	________________	___________
High cholesterol levels	________________	___________
Cancer – please state type of cancer:	________________	___________
Dementia/Alzheimers	________________	___________
Diabetes	________________	___________
Eye disease	________________	___________
Genetic disorders	________________	___________
Heart disease	________________	___________
High blood pressure	________________	___________
Osteoporosis	________________	___________
Stroke	________________	___________
Other: ___________	________________	___________

If any of the above family members you listed are deceased, please give age at death and reason:

SOCIAL HISTORY

Occupation: ______________

Education
- ☐ Less than 9th grade
- ☐ High school
- ☐ 2 year college
- ☐ 4 year college
- ☐ Post graduate

Marital Status
- ☐ Married
- ☐ Single
- ☐ Divorced
- ☐ Separated
- ☐ Widowed
- ☐ Domestic partner

Exercise Level
- ☐ None (No exercise)
- ☐ Occasional exercise
- ☐ Moderate exercise
- ☐ High level exercise

Type: ______________

Caffeine (include Tea)

☐None

-or-

# of cups/cans per day? _____

Drugs

Do you currently use recreational or street drugs?

☐Yes ☐No

If yes, list: ____________

Alcohol

Do you drink alcohol?

☐Yes ☐No

If so, how often?

☐Occasionally

☐< 3 times a week

☐> 3 times a week

How many drinks per week? __

Tobacco Use:
- ☐ Never Smoked
- ☐ Former Smoker:
  Year quit? __________
- ☐ Chewing Tobacco
  Type: __________
- ☐ Secondhand smoke exposure
- ☐ Current everyday smoker
  Amt: __________
- ☐ Current some day smoker
  Amt: __________

REVIEW OF SYSTEMS

Have you ***recently*** had reoccurring symptoms of any of the following:

Allergic/Immunologic
- ▢Frequent Sneezing
- ▢Hives
- ▢Itching
- ▢Runny Nose
- ▢Sinus Pressure

Cardiovascular
- ▢Arm Pain on Exertion
- ▢Chest Heaviness /Pressure on Exertion
- ▢Chest Pain on Exertion
- ▢Irregular heart beats (palpitations)
- ▢Known heart murmur
- ▢Light-headed on standing
- ▢Shortness of breath when lying down
- ▢Shortness of breath when walking
- ▢Swelling (edema)

Eyes
- ▢Dry Eyes
- ▢Irritation
- ▢Vision Change

Ears/Nose/Mouth/ Throat
- ▢Bleeding Gums
- ▢Dizziness
- ▢Difficulty Hearing
- ▢Dry Mouth
- ▢Ear Pain
- ▢Frequent Nosebleeds
- ▢Frequent Infections
- ▢Hoarseness
- ▢Mouth Breathing
- ▢Mouth Ulcers
- ▢Nose/Sinus Problems
- ▢Ringing in Ears

Endocrine
- ▢Fatigue
- ▢Increased Thirst / Hunger / Urination

Gastrointestinal
- ▢Abdominal Pain
- ▢Black or Tarry Stool
- ▢Blood in Stool
- ▢Change in Appetite
- ▢Frequent Indigestion
- ▢Hemorrhoids
- ▢Trouble Swallowing
- ▢Vomiting
- ▢Vomiting Blood

Constitutional
- ▢Exercise Intolerance
- ▢Fatigue
- ▢Fever
- ▢Weight Gain (____lbs)

Genitourinary
- ▢Blood in Urine
- ▢Difficulty Urinating
- ▢Incomplete Emptying
- ▢Increased Urinary Frequency
- ▢Urinary Loss of Control
- ▢Erectile Dsyfunction
- ❑Do you use condoms? Y / N
- ❑Other form of birth control? _____________
- ❑Interested in being screened for STD's? Y / N

Hematologic/Lymphatic
- ▢Easy Bruising /Bleeding
- ▢Swollen Glands

Integumentary (Skin)
- ▢Changes in Moles
- ▢Dry Skin
- ▢Eczema
- ▢Growth/Lesions
- ▢Itching
- ▢Jaundice (Yellow Skin/Eyes)
- ▢Rash

Musculoskeletal
- ▢Back Pain
- ▢Joint Pain
- ▢Muscle Aches
- ▢Muscle Weakness

Neurological
- ▢Fainting
- ▢Dizziness
- ▢Headaches
- ▢Memory Loss
- ▢Migraines
- ▢Numbness
- ▢Restless Legs
- ▢Seizures
- ▢Weakness

Respiratory
- ▢Cough
- ▢Coughing Up Blood
- ▢Shortness of Breath
- ▢Sleep Apnea
- ▢Snoring
- ▢Wheezing

Psychiatric
- ▢Alcohol Overuse
- ▢Anxiety/Stress
- ▢Depression
- ▢Do Not Feel Safe in Relationship(s)
- ▢Mania
- ▢Sleep Problems

Please list any and all other doctors and/or medical specialists you are currently seeing (Include GYN, eye doctor, and dentist):

____
____
____
____

Please add any other information about your health that you would like your provider to know here:

____
____
____
____

____ ______________________

Patient **OR** Parent, Guardian, or Caregiver Signature Date