Mt. Pleasant Internal Medicine

498 Wando Park Blvd. Ste 500
Mt. Pleasant, SC 29464

Ph: 843-881-1671 **Fax: 843-881-1433**

PATIENT INFORMATION

DATE: ________________________

Patient's Name ______________________ ____________________________ Nickname: ________________________
First MI Last

Date of Birth: _____________________ Mailing Address: ____

(PLEASE CIRCLE) Sex: Male Female ____

Social Security Number: ___________________________

Ethnicity: (__)Hispanic/Latino (__)NOT Hispanic/Latino Race: ________________ Language: English ( )Yes ( ) No

□ Home Ph: (___) ________________ □ Work Ph: (___) ________________ □ Cell Ph: (___) ___________________
*WHICH OF THE ABOVE IS YOUR PREFERRED MEANS OF CONTACT: PLEASE CHECK **ONE**

May we leave a message on your home answering machine? ………( ) Yes ( ) No _______INITIAL
May we leave a message for you at work to call us? ………………...( ) Yes ( ) No _______INITIAL
May we email you? …………………………………………………( ) Yes ( ) No _______INITIAL

email: ______________________@__________________.________

Spouses Name: ____ Spouses Phone for emergencies: __________________

Emergency Contact (other than spouse): _______________________________Phone Number: (___) ________________________

Responsible Party if different from patient: __________________________________Responsible party DOB:__________________

Responsible party SS#:_________________________ Responsible Party Ph #: ___________________________________

Responsible Party Mailing Address: ____

Patient's Employer: __________________________________ Employer's Ph #: ___________________________________

Other Family Members that are Patients: ____

May we discuss your medical condition with another person? ( ) Yes ( ) No _______ INITIAL

If yes, whom? ____Relationship: _________________________

____Relationship: _________________________

Pharmacy Choice: ___________________________________Pharmacy Phone Number: _________________________

I authorize the release of medical information to other physicians, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician.

Patient or Responsible Party Signature ____Date ____/____/____

(Insurance Card, Picture ID, and any copayment/coinsurance/deductible must be provided at time of service)
IF INSURED UNDER SPOUSE, PARENT, GUARDIAN, OR ARE A MINOR, PLEASE COMPLETE ITEMS BELOW FOR POLICY HOLDER:

Policy Holder's Name: _____________________________ Date of birth:____/____/____ SS # _______-_______-________

Relationship to Insured: (CIRCLE ONE) (Self / Parent / Spouse)

I hereby assign, transfer and set over to, Mt Pleasant Internal Medicine all of my rights, title and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. Payment is required for all services at the time they are rendered unless I am in an insurance plan in which they participate. For those patients, applicable co-payments and deductibles will be collected at the time of service.

Patient or Responsible Party Signature ____Date ______/______/______

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MEDICAL HISTORY

TODAY'S DATE: ____________________

Last Name: ________________________________ **First Name:**__________________________________ **M.I.**________

DOB: ___________/_________/____________ **Marital Status: [ ]Single [ ]Married [ ]Divorced [ ]Widowed**

Alcohol: [ ]Never [ ]Occasional/Socially [ ]Daily

Tobacco: [ ]No [ ]Never [ ]Yes [ ]Occasional ________ packs/day Year Stopped ________ Cigars/Smokeless

Have you ever been diagnosed with any of the following medical conditions?

____ Asthma	____Hepatitis/Liver Disease	____Migraines
____Blood Clots/DVT/Phlebitis	____Herniated Disc	____Seizures
____Cancer	____High Cholesterol	____Stroke
____Diabetes	____Hypertension/High Blood Pressure	____Thyroid Disease
____Emphysema/COPD	____Heart Attack	
____Heart Failure	____Kidney Disease	

Please list any other medical diagnoses or problems: ____
____
____
____

Please list any surgeries or hospital admissions: ____
____
____
____

List all Prescription medications that you are currently taking:

Drug Drug Strength/Dose Frequency

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____
7. ____
8. ____

List any non-prescription (over-the-counter) medicines that you take regularly:
____
____

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Patient Name: ____ DOB: _____________________ Today's Date:________________

Please list drug allergies and describe any reaction to this medication:

____

____

____

Please describe the medical history of your immediate family listing any major problems such as heart disease, diabetes, cancer, high blood pressure, stroke, TB, neurological disease, and whether living or deceased (L/D):

	L / D	Age	Major Medical Problems
Mother			
Father			
Sister(s)			
Brother(s)			
Mt.G-Mother			
Pt.G-Mother			
Mt.G-Father			
Pt.G-Father			
Daughter			
Son			

Please circle any symptoms or problems that you are currently experiencing:

Abdominal/Pelvic Pain
Abnormal Vaginal Discharge
Abnormal Weight Gain
Anxiety
Blood in Urine
Blood in Stool
Black Stools
Breast Mass / Tenderness
Chronic Cough
Chronic Diarrhea
Chronic Constipation
Chest Pain
Depression
Difficulty Hearing
Fatigue

Faintness/Dizziness
Fever/Chills
Frequent Urination
Frequent Nose Bleeds
Headaches
Heart Racing
Heartburn
Impotence
Memory Problems
Muscle/Joint Pain
Nausea
Night Sweats
Numbness in Arms or Legs
Palpitations
Shortness of Breath

Skin Rashes
Swelling of the Legs or Feet
Swollen Glands or Lymph Nodes
Testicular Pain / Mass
Tremor
Trouble Swallowing
Trouble Urinating
Ulcers of the Skin
Unintentional Weight Loss
Vertigo
Vision Problems
Weakness in General
Weakness in Arms or Legs
Wheezing

Completed by: [ ] Patient: Patient Signature: ____Date: _______/_______/______

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FINANCIAL POLICY AND DISCLOSURE

Patient Name: ____ DOB:______________________________

The Financial Policy and Disclosure is to help Mt Pleasant Internal Medicine provide the most efficient and reasonable health care services. Therefore, it is necessary for us to have a Financial Policy and Disclosure stating our requirements for payment for services provided to patients.

Self-Pay Policy:

- Patients without health insurance will receive a discount at time of check-out when making payment IN FULL.
- If you are a self-pay patient, you will be required to pay your balance in full at the time of service.
- If you are unable to pay the balance at the time of service, a financial agreement may be established and must be agreed upon and signed before provision of services.

Insurance Policy:

- It is our policy to file for insurance as a courtesy to you if we have accurate and complete insurance information.
- If a service is provided that is not covered by your insurance company, you will be the responsible party at the time of service. Not all insurance companies pay for vaccines, injections, labs, or procedures performed in our office. Please be aware of your insurance policies; payment for these services is your responsibility at the time that they are rendered unless an agreement is made in advance with our billing coordinator.
- If we have not received a payment from your insurance company within thirty (30) business days, you will be responsible for the balance due.
- Deductibles, co-payments, coinsurance, and past due balances will be collected at the time of service.
- In special cases, we may need your help in contacting your insurance company for the payment of your services, and therefore you must agree to cooperate in assisting us fully should that be necessary.

Cancellation / No-Show:

- We understand that situations arise in which you must cancel your appointment. Therefore, we request that you provide advance notice whenever possible to allow an opportunity for another patient in need to be seen.

Check Policy:

- Any returned checks will be credited back to your account, and a $35.00 returned check fee will be added. You will have one week to return to the office with cash or money order.

WE ASK THAT YOU ASSIST US BY:

1. Providing us with current and updated information on yourself and your insurance company.
2. Presenting an updated photo identification card and insurance card when changes are made.
3. Making the appropriate payment at the time of service, whether it is a deductible, co-pay, coinsurance, or for the full amount if you are a Self-Pay Patient.

Labs, Procedures, and Imaging:
We will contact you as soon as possible if any of your test results require prompt attention.
May we send lab results to you via your email address? YES / NO **INITIAL: ______** Email:______________________
May we leave messages with lab results on your answering machine? YES / NO **INITIAL: _____** Ph#:_____________
Acknowledgments: I acknowledge and agree to the terms and conditions of the Policies described, and all of the above information is correct. Finance charges may be applied to unpaid balance over 30 days old.

____ ____________________________
Responsible Party's Signature **Date**

ASSIGNMENT OF BENEFITS

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ALL INSURANCE EXCEPT MEDICARE

I authorize my insurance company to pay benefits on my behalf directly to Mt. Pleasant Internal Medicine. I authorize Mt. Pleasant Internal Medicine to provide to my insurance company any information necessary to process claims for services rendered to me.

____ ____________________

Signature of Patient/Guardian **Date**

MEDICARE

I authorize medical or other information about me to be released to the Social Security Administrations and Health Care Financing Administration or its intermediaries or carrier needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations about Medicare assignment of benefits apply.

- **Are you covered by any other insurance that makes Medicare secondary? Y / N**
  If Medicare is your secondary insurance, please circle the type of coverage you have:

1. Working Aged/Spouse Group Plan	6. Veteran's Admin
2. ESRD	7. Disabled
3. No-Fault/Auto Primary	8. Beneficiary Under age 65
4. Worker's Comp	9. Other Liability Ins is Primary
5. Public Health Service/Other Fed Agency	10. Black Lung

____ ____________________

Signature of Patient/Guardian **Date**

MEDIGAP

If you have a supplemental policy and it is a MEDIGAP policy to which you're Medicare Carrier automatically "crosses over," we are required to keep a separate signature on file:
I request authorized MEDIGAP benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to my MEDIGAP carrier any information needed to determine these benefits or the benefits payable for related services.

____ ____________________

Signature of Patient/Guardian **Date**

Do you or your spouse work in a company which has more than 20 employees and have coverage through insurance at that job? YES _______ NO ________

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NOTICE OF PRIVACY PRACTICES
OF
Mt. Pleasant Internal Medicine

Effective: April 14, 2003

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION, PLEASE REVIEW CAREFULLY.

All patients have the right to know that their Personal Health Information (PHI) remains confidential. The Privacy Rights and Practices of Mt Pleasant Internal Medicine were established to protect the healthcare information of our patients as required by Section 164.520 of the Health Insurance Portability and Accountability Act (HIPAA) of 1996. These guidelines restrict the release of your medical information for treatment, payment, and healthcare operations. The following are examples of agencies or facilities to which your personal health information may be released in the course of your treatment:

- Health Insurance Providers
- Pharmacies
- Laboratory Testing Facilities
- Hospitals
- Physician Consults
- Surgical Facilities
- Physical Therapies

Other uses or disclosures permitted or required by law:

- Public Health Activities
- Health Inspection Agencies
- Law Enforcement Purposes
- Workers' Compensation
- Specialized Government Functions (Military or Veterans' Activities)
- Reporting Abuse, Neglect, or Domestic Violence
- Judicial Proceedings
- Disclosures about Decedents (Coroner/Funeral Director)
- Avert Serious Threat to Public Health or Safety

THE RELEASE OF HEALTHCARE INFORMATION TO ANY OTHER SOURCE IS PROHIBITED WITHOUT THE WRITTEN AUTHORIZATION OF THE PATIENT OR GUARDIAN.

As a patient or guardian, you have the right to:

- Request restrictions on certain uses and disclosures of your health care information;
- Inspect and request changes to your medical records;
- Obtain a copy of your medical record (Fee charged for copies);
- Find out what disclosures of your record have been made;
- Receive confidential communications;
- Ask questions about the Privacy Policy; and
- File a complaint with Mt. Pleasant Internal Medicine or the Secretary of Health and Human Services without the fear of any reprisals, if you believe your privacy rights have been violated.

Mt. Pleasant Internal Medicine is required by law to abide by the terms outlined in this notice. However, Mt. Pleasant Internal Medicine reserves the right to change the terms of this Privacy Notice and make the new provisions effective for all protected health information that we maintain. Any revisions of this notice will be posted and distributed during office appointments.

If you need help reading or understanding this form, please tell the Receptionist.

You may also request a copy of our entire Notice of Privacy Practices for your review and your retention.

Patient Name: ____ DOB ______________________

Patient / Guardian Signature: ____ Date: ______________________

Witness: ____ Date: _______________________