Print Packet

# Patient Information and Consent

Please Print

## Patient Name

Legal First Name | Legal Last Name | Suffix | Preferred First Name

## Today's Visit

What is the reason for your visit today? _____

Have you been treated at any Doctors Care office location before? ☐ Yes ☐ No

Have there been any changes to your information in the past 6 months? ☐ Yes ☐ No (if no, please skip to the back page)

## Patient Demographics

Permanent Address | Apt. # | City | State | Zip

Phone # | Social Security # | Gender | Birth Date

Language | Marital Status | Email Address (We will never rent or sell your email address – we value your privacy.)

Local or Alternate Address | Alternate Phone # | Today's Date

Race: ☐ African American ☐ American Indian/Alaska Native ☐ Asian ☐ Hispanic ☐ Mixed Race ☐ White ☐ Other ☐ Refuse to Report

Ethnicity: ☐ Hispanic ☐ Not Hispanic ☐ Refuse to Report

## Emergency Contact Information

Contact Name | Phone # | Relationship to Patient

Name of a Relative not Residing With You | Phone #

## Patient Employment Information

Employer Name | Employer Phone #

## Responsible Party's Information (if someone other than patient)

Legal Name of Responsible Party | Social Security # | Address | City | State | Zip

## Medical Insurance Information

Insurance Company | Policy Holder's Name | Policy Holder's Relationship to Patient

Policy Holder's Address | City | State | Zip

Policy Holder's Birth Date | Policy Holder's Social Security # | Policy Holder's Employer

**PLEASE TURN THIS FORM OVER AND COMPLETE THE BACK**

## Patient Consent for Treatment

1. I voluntarily consent to any and all health care treatment and diagnostic procedures provided by Doctors Care and its associated physicians, clinicians and other personnel. I am aware that the practice of medicine and other health care professions is not an exact science and I further state that I understand that no guarantee has been or can be made as to the results of the treatments or examinations at Doctors Care.
2. I consent to the use and disclosure of my/the patient's protected health information for purposes of obtaining payment for services rendered to me/the patient, treatment and health care operations consistent with the Doctors Care Notice of Privacy Practices.
3. I authorize payment of medical benefits to Doctors Care physicians or their designee for services rendered.
4. I give permission to obtain all my medication/prescription history when using an electronic system to process prescriptions for my medical treatment.

I have received a copy of the Notice of Privacy Practice, Financial Policy Notice and the Release of Information. ☐ Yes ☐ No Initial _____

_____ _____
Patient or Authorized Person's Signature Date

## Workers Compensation Patients

I hereby authorize Doctors Care to speak to a rehabilitation specialist, my employer, my insurance carrier or other professionals involved in my care of rehabilitation, regarding my medical records and the treatment I have received or will receive.

_____ _____
Patient or Authorized Person's Signature Date

## In-House Medication Program (please read and sign)

In order to better serve you, Doctors Care has a medication program, which allows you to take home medications directly from our office.

- Our program allows you to fill your prescriptions while you are in our office
- In most cases, our prices are comparable to your insurance co-pay or those offered at your local pharmacy
- In-house medications **will not** be filed to your insurance and will not go toward you deductible

**Please Note: This is a cash/credit/check pay only program. Nothing will be filed to your insurance.**

Are you interested in having your prescriptions filled at Doctors Care?

☐ Yes ☐ No ☐ I may consider purchasing once evaluated by the provider on duty

_____ _____
Patient or Authorized Person's Signature Date

**FOR INTERNAL USE ONLY**

HPM Account Number: _____ Co-Pay Collected: $ _____

EMR DOCUMENT TYPE: Patient Information

# Patient Medical History

Today's Date: _____

Patient Name: _____ Date of Birth: _____

## Allergies

If you have no known allergies, please check the box at right. ☐ No known allergies to report

1. Medication: _____ Reaction: _____
2. Medication: _____ Reaction: _____

## Major Illnesses (please check all that apply)

| | | | | |
|---|---|---|---|---|
| Hypertension: | ☐ Current | ☐ Past | ☐ N/A | Notes: _____ |
| Diabetes: | ☐ Current | ☐ Past | ☐ N/A | Notes: _____ |
| Cancer: | ☐ Current | ☐ Past | ☐ N/A | Notes: _____ |
| Other: | ☐ Current | ☐ Past | ☐ N/A | Notes: _____ |

## Surgeries (please list all major surgeries with estimated dates)

If you have never had any major surgeries, please check the box at right. ☐ No surgeries to report

_____

_____

## Family History

| | | | | | |
|---|---|---|---|---|---|
| Mother: | ☐ Hypertension | ☐ Diabetes | ☐ Cancer | ☐ Other (please specify) _____ | ☐ N/A |
| Father: | ☐ Hypertension | ☐ Diabetes | ☐ Cancer | ☐ Other (please specify) _____ | ☐ N/A |
| Brother: | ☐ Hypertension | ☐ Diabetes | ☐ Cancer | ☐ Other (please specify) _____ | ☐ N/A |
| Sister: | ☐ Hypertension | ☐ Diabetes | ☐ Cancer | ☐ Other (please specify) _____ | ☐ N/A |
| Grandmother (M): | ☐ Hypertension | ☐ Diabetes | ☐ Cancer | ☐ Other (please specify) _____ | ☐ N/A |
| Grandmother (P): | ☐ Hypertension | ☐ Diabetes | ☐ Cancer | ☐ Other (please specify) _____ | ☐ N/A |
| Grandfather (M): | ☐ Hypertension | ☐ Diabetes | ☐ Cancer | ☐ Other (please specify) _____ | ☐ N/A |
| Grandfather (P): | ☐ Hypertension | ☐ Diabetes | ☐ Cancer | ☐ Other (please specify) _____ | ☐ N/A |

## Social History

| | | | | |
|---|---|---|---|---|
| Drink alcohol: | ☐ Currently | ☐ In the past | ☐ Never | How much and how often? _____ |
| Use tobacco products: | ☐ Currently | ☐ In the past | ☐ Never | How much? _____ |
| Substance abuse: | ☐ Currently | ☐ In the past | ☐ Never | What substance? _____ |

## Medications with Dosages (if you need more space, please use back of form)

If you are not currently taking any medications, please check the box at right. ☐ No medications to report

_____

_____

## Other Information

Preferred pharmacy name: _____ Date of Last Tetanus Shot: _____

Preferred pharmacy address: _____

Last Menstrual Period: _____ Are you ☐ Pregnant ☐ Breastfeeding

## Patient Acknowledgement

To the best of my knowledge, the information provided above is accurate and complete.

_____ _____

Patient or Authorized Person's Signature Date

EMR DOCUMENT TYPE: Patient Information

# Notice of Privacy Practices: Doctors Care, PA

Please Read and Sign

**This notice describes how medical information about you may be used, disclosed, and how you can get access to this information. Please review this document carefully.**

**Patient Health Information (PHI)**

Under federal law, your patient health information (PHI) is protected and confidential. Patient health information (PHI) includes information about your symptoms, test results, diagnosis, treatment, and related medical information. Your patient health information (PHI) also includes payment, billing and insurance information. We are committed to protect the privacy of your PHI.

**How we use your patient health information (PHI)**

This Notice of Privacy Practices (Notice) describes how we may use within our practice or network and disclose (share outside of our practice or network) your PHI to carry out treatment, payment or health care operations, for administrative purposes, for evaluation of the quality of care, and so forth. We may also share your PHI for other purposes that are permitted or required by law. This Notice also describes your rights to access and control your PHI. Under some circumstances we may be required to use or disclose your PHI without your consent.

Treatment: We will use and disclose your PHI to provide you with medical treatment or services. We may also disclose your PHI to other health care providers who are participating in your treatment, to pharmacists who are filling your prescriptions, to laboratories performing tests, and to family members who are helping with your care, and so forth.

Payment: We will use and disclose your PHI for payment purposes. For example, we may need to obtain authorization from your insurance company before providing certain types of treatment. We will submit bills and maintain records of payments from your health plan. PHI may be shared with the following: billing companies, insurance companies (health plans), government agencies in order to assist with qualifications of benefits, or collection agencies.

Operation: We may ask you to complete a sign-in sheet or staff members may ask you the reason for your visit so we can better care for you. Despite safeguards, it is always possible in a doctor's office that you may learn information regarding other patients or they may inadvertently learn something about you. In all cases, we expect and request that our patients maintain strict confidentiality of PHI.

We may use and disclose your PHI to perform various routine functions (e.g. quality evaluations or records analysis, training students, other health care providers or ancillary staff such as billing personnel, to assist in resolving problems or complaints within the practice). We may use your PHI to contact you to provide information about referrals, for follow-up with lab results, to inquire about your health or for other reasons. We may share your PHI with Business Associates who assist us in performing routine operational functions, but we will always obtain assurances from them to protect your PHI the same as we do.

Special Situations that DO NOT require your permission: We may be required by law to report gunshot wounds, suspected abuse or neglect, and so on; we may be required to disclose vital statistics, diseases, and similar information to public health authorities; we may be required to disclose information for audits and similar activities, in response to a subpoena or court order, or as required by law enforcement officials. We may release information about you for worker's compensation or similar programs to protect your health or the health of others or for legitimate government needs, for approved medical research, or to certain entities in the case of death. Your PHI may also be shared if you are an inmate or under custody of the law which is necessary for your health or the health and safety of other individuals.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose PHI of individuals who are Armed Forces personnel for activities deemed necessary by appropriate military command authorities, for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or to foreign military authority if you are a member of that foreign military services.

In some situations, we may ask for your written authorization before using or disclosing any identifiable health information about you. If you sign an authorization, you can later revoke the authorization.

**Individual Rights**

You have certain rights with regard to your PHI, for example:

Unless you object, we may share your PHI with friends or family members, or other persons directly identified by you at the level they are involved in your care or payment of services. If you are not present or able to agree/object, the healthcare provider using professional judgment will determine if it is in your best interest to share the information. We may use or disclose PHI to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. We may use or disclose your PHI to an authorized public or private entity to assist in disaster relief efforts.

You may request restrictions on certain uses and disclosures of your PHI. We are not required to accept all restrictions. If you pay in full for a treatment or service immediately, you can request that we not share this information with your medical insurance provider or our Business Associates. We will make every attempt to accommodate this request and, if we cannot, we will tell you prior to the treatment.

You may ask us to communicate with you confidentially by, for example, sending notices to a special address.

In most cases, you have the right to get a copy of your PHI. There will be a charge for the copies.

If you believe information in your record is incorrect, or if important information is missing, you have the right to request that we amend the existing information by submitting a written request. You may request a list of instances where we have disclosed PHI about you for reasons other than treatment, payment, or operations. The first request in a 12 month period is free. There will be charges for additional reports.

You have the right to obtain a paper copy of this Notice from us, upon request. We will provide you a copy of this Notice on the first day we treat you at our facility. In an emergency situation we will give you this Notice as soon as possible. You have the right to receive notification of any breach of your protected health information.

**Our Legal Duty**

We are required by law to protect and maintain the privacy of your PHI, to provide this Notice about our legal duties and privacy practices regarding PHI, and to abide by the terms of the Notice currently in effect. We may update or change our privacy practices and policies at any time. Before we make a significant change in our policies, we will change our Notice and post the new Notice in the admissions area and on our website at www.DoctorsCare.com. You can also request a copy of our Notice at any time.

If you are concerned about your privacy rights, or if you disagree with a decision we made about your records, you may contact the Privacy Officer listed below. You may also send a written complaint to the U.S. Department of Health and Human Services. You will not be penalized in any way for filing a complaint.

**Contact Person**

If you have any questions, requests, or complaints, please contact:

Doctors Care
Attn: Privacy Officer
1600 Hwy 17 North
Surfside Beach, SC 29575

Email: privacyofficer@doctorscare.com

HIPAA South Carolina
US DHHS
Atlanta Federal Center
Suite 3B70
61 Forsyth Street
Atlanta, GA 30303-8909

## Patient Acknowledgement

My signature verifies that I have been provided a copy of Doctors Care "Notice of Privacy Practices" to review. I understand that if I would like a copy of this Notice, Doctors Care will provide me with a copy of this documentation.

| Patient's Name (please print) | Date of Birth | Signature | Today's Date |
|---|---|---|---|

EFFECTIVE APRIL 2013
EMR DOCUMENT TYPE: Patient Information

# Authorization for Release of Information

Patient Name: _____ DOB: _____

_____ is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

| **Entity to Receive Information.** Check each person/entity that you approve to receive information. | **Description of information to be released.** Check each that can be given to person/entity on the left in the same section. |
|---|---|
| ☐ Voice Mail | ☐ Results of lab tests/x-rays<br>☐ Other: _____ |
| ☐ Spouse (provide name & phone number)<br>_____ | ☐ Financial<br>☐ Medical |
| ☐ Parent (provide name & phone number)<br>_____ | ☐ Financial<br>☐ Medical |
| ☐ Email communication (provide email address)*<br>_____ | ☐ Financial<br>☐ Medical<br>☐ Breach Notification |

*In order for email communication to occur, please accept the disclosure below:

_____ I understand that if email is not sent in an encrypted manner, there is a risk it could be accessed inappropriately. I still elect to receive email communication.
Initial

## Patient Information

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

*I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.* This authorization shall be in effect until revoked by the patient.

_____ _____
Signature of Patient or Personal Representative Date

_____
Description of Personal Representative's Authority (attach necessary documentation)

# Financial Policy and Disclosure

Please Sign and Date

The Financial Policy and Disclosure is to help us 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.

Patients are responsible for the payment of all services provided by Doctors Care and UCI Medical Affiliates.

**Self-Pay Policy**

- If you are a self pay patient, you will be required to pay for the office visit before services are rendered.
- In addition, any remaining balance on your account will be collected at discharge.

**Insurance Policy**

- If you are an insurance patient, 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.
- If we have not received a payment from your insurance company within thirty (30) days, you will be responsible for the balance due.
- Deductibles, co-payments, and coinsurance will be collected before services are rendered.
- In special cases, we may need your help in contacting your insurance company for the payment of your services.

**Workers Compensation Policy**

- If you are a workers compensation patient, it is our policy to bill your employer or the worker's compensation carrier for services rendered.
- If you are covered under worker's compensation, we will accept the payments by the worker's compensation carrier as per contracted rates based on the mandated SC state fee schedule.
- If payment is denied from your worker's compensation carrier, you will become responsible for the entire balance of your services. Payment will be due within ten (10) days following any worker's compensation payment denial.
- It will be your responsibility to contact us with the name and address of your employer or the insurance company that covers your employer.

**X-Ray Policy**

- If you require an x-ray on today's visits, the x-ray will be sent out to a Radiologist for a second opinion for quality assurance purposes.
- You will be responsible for the cost of this service if your insurance company chooses not to cover it.

**Overdue and Credit Balances**

- All over-due patient balances will be sent to collections.
- All accounts sent to collections will be charged a $25 collection fee in addition to the account balance.
- Credit balances under $15 aged over 60 days may be written off.

**Divorce or Custody Case Policy**

- The parent or guardian who brings the patient into our office will be held financially responsible, regardless of the provisions in the divorce decree, or who has custody, or who has the insurance.

To help in this policy, 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, copay, coinsurance, or for the full amount if you are a Self-Pay Patient.

In order to provide the best medical care, we ask that you do not discuss your account balance or financial aspects with the physician(s) or medical staff. Please discuss any account information with the check out associate or front desk.

Responsible Party's Signature _____ Date _____

Your cooperation is greatly appreciated.

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