University Medical Associates of Aiken

PATIENT REGISTRATION FORM

Patient Information

Last Name: _____ First Name: _____ M.I. _____

Marital Status: _____ DOB: _____/_____/_____ Race:_____ Sex: _____Male _____Female

Address: _____ City: _____ State: _____ Zip: _____

Home Telephone: _____ Mobile/Work Phone: _____ SSN: _____

Driver's License Number: _____ Driver's License Expiration Date: _____ State of License: _____

Email: _____ Occupation: _____ Preferred Means of Contact: _____

Employer Name and Address: _____

EMERGENCY CONTACT:
Name: _____ Phone: _____ Relationship: _____

I authorize UMA of Aiken to disclose my protected health information to the family member(s)/individual(s) listed below. UMA of Aiken may discuss:

- Medical information relating to my care
- Payment for medical services performed on my behalf
- Information relating to the start/end of my appointments

Disclosure is authorized for the following person(s):

1. Name:_____ Relationship to Patient _____
2. Name:_____ Relationship to Patient _____
3. Name:_____ Relationship to Patient _____
4. □ **I authorize disclosure to no one at this time**

Signature: _____

Do you have an Advanced Directive? ____ Yes _____ No

If yes, please provide a copy to our office within 30 days from today's date. (Note: If a copy not provided as directed, UMA of Aiken shall not be liable for the contents of any advanced directive.)

HOW DID YOU HEAR ABOUT US?

□ Referral? From whom? _____

□ Newspaper

□ Insurance Plan

□ Phone Book

□ Internet

Primary Policy Holder's Insurance Information

IF SAME AS PATIENT PLEASE CHECK HERE AND PROVIDE CARD: _____
(If different from patient or if card is not available, please complete the information below for primary insurance):

Last Name: _____ First Name: _____ M.I. _____ DOB:_____

INS ID#_____SSN: _____ Relationship to Patient: _____

Secondary Insurance Policy

Last Name: _____ First Name: _____ M.I. _____ DOB:_____

INS ID#_____SSN: _____ Relationship to Patient: _____

I understand that I am responsible for payment in full of all charges. I authorize that payment of benefits from my insurance be paid directly to UMA of Aiken. I also authorize UMA of Aiken to release to my insurance company any and all information necessary for the processing of insurance claims. If UNINSURED, payment for services is due at time services are rendered.

Signature: _____ Date: _____

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Practice Guidelines and Financial Policies

Please read, initial each policy item and sign below.

_____**1. Emergencies** Our providers will make every effort to receive your calls and respond promptly in an emergency. If you do not receive an immediate response you need to call 911, receive paramedic intervention, and seek the nearest emergency room.

_____**2. Prescription refills** It is our policy that it is the patients responsibility to know when your medications need be refilled at least a week before you run out. Medications are refilled only at the patient visit. This includes all mail-order prescriptions. We cannot take weekends, walk-ins, after hours, or phone call refill requests.

_____**3. Telephone encounters and sick patients** Our practitioners do not treat new patients or new illnesses over the phone. The physician or physician assistant may elect to treat an existing patient seeking continuing care for an existing straightforward illness over the telephone. Patients seeking such services in a habitual manner will be charged a fee of $35.00. Insurance companies do not cover costs for these encounters. Payment for these services is your responsibility.

_____**4. Information** You agree to provide your current name, current and correct addresses, cellular or other phone number, email address, insurance information, Social Security number, driver's license or picture identification at the time of registration or as requested by the practice at any time.

_____**5. Financial responsibility** By these initials and your signature below, you accept financial responsibility for all charges for services rendered to you. *If a minor, the parent or guardian accompanying the patient assumes the liability.*

_____**6. Payment methods** We accept cash, check, and several major credit cards. It is the responsibility of the patient to contact their insurance company to verify that our providers participate with your plan.

____**7. Appointments** Our office will schedule appointments as a common courtesy for patients and in consideration of your time. Minors must be accompanied by a parent or guardian to be seen unless special arrangements have been made with the office. We require a minimum of 24 hours (or the Friday before a Monday appointment) notice of cancellation as a courtesy to other patients seeking services. A fee of $30.00 will be charged for non-cancelled and missed appointments. A pattern of non-cancelled missed appointments may result in discharge from the practice. Patients more than 30 minutes late to their scheduled appointment will be asked to reschedule their appointment for a later date.

_____**8. Form fees** Our practice charges for additional paperwork outside of the completion of the medical record. The following fees apply and are subject to change without notice: (a) single page forms- $20.00 (b) multi-page forms-$40.00, i.e. FMLA, immigration, disability, and driver's license form. Fees are paid up front before completion of forms.

_____**9. Medical records** The medical chart is the property of the practice. However, copies of your permanent medical information are available upon request. We will electronically transfer your records one time as a courtesy to you. The practice charges a copy fee for any records printed.

_____**10. Insurance copayments, deductibles and coinsurances** Insurance companies do not pay all fees and may exclude services from coverage. It is your responsibility to understand your insurance plan. All copayments, deductibles, coinsurance or noncovered services are to be paid in a timely fashion according to

office policies. You accept responsibility for all such expenses ever as your insurance company is billed as a courtesy.

_____**11. Accident and worker's compensation** Although our office is happy to treat your medical condition, if the cause is related to an auto or work-related accident you will be required to pay the full fees at the time of your visit, unless we are contracted with your employer for such services.

_____**12. Statement policy** Our office sends patient statements each month. Payments are due upon receipt of the statements. You understand that if we participate with your insurance company the sending of a statement may be delayed until your insurance responds to a claim for services. Such a delay can take months. You understand that such a delay does not alter our policy of patient financial responsibility and you will be liable for all service fees. A late fee may be charged for patient balances due that are more than 30 days old.

_____**13. Collection and bank fees** Accounts more than 90 days old are subject to transfer to an outside collection agency. These agencies charge fees. You agree to be liable for all such collection expense, legal fees, and court costs. In addition, banks charge for checks that do not clear or cannot be cashed. You agree to be liable for all such fees and may be charged for patient balances due that are more than 30 days old.

_____**14. Patient discharge** The practice reserves the right to discharge a patient for any reason. Please note that discharges may occur for failure to meet your obligations under this document. In addition, because of care quality considerations, the practice may discharge you for failure to comply with treatment plans (s) as outlined by your practitioner.

_____**15. Insurance claims** If applicable, our office will submit insurance claims. You agree to allow our practice to "accept assignment" of benefits and receive payment directly for your insurance company. In the event your insurer sends payment for claims from our office to you directly, you agree to endorse the payment in fulfillment of any amount due within 10 days of postmark.

_____**16. Patient Consent for Use and Disclosure of Protected Health Information**

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination an test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means for communicating amount health professionals contributing to my care
- A source for information for applying my diagnosis to my bill
- A means by which a 3rd payor can verify that services billed were provided
- A tool for assessing quality and reviewing the competence of healthcare professionals

I hereby give my consent for UMA of Aiken to use and disclose protected health information about me to carry our treatment, payment, and health care operations hereafter referred to as TPO.

I have read and understand all the terms of this policy and by my initials and my signature below, I attest that I fully understand each item and agree to the terms above.

Signature _____

Date _____

Print Name _____

University Medical Associates of Aiken

PEDIATRIC HISTORY

Welcome to our practice! To provide you with the best, most comprehensive care possible, we request that you provide the following information. All information is held strictly confidential and is released only with your written permission.

Name:	Date of Birth:
Age:	Today's Date:
Parent(s) Names:	School Grade:

SOCIAL HISTORY

Birth Parents Names:	
Where there any problems with the pregnancy, labor, or delivery? Yes No	
Child's Birth Weight: _____ lbs _____ oz.	If yes, please explain:

FAMILY HISTORY

Please be sure to list any family problems below including: **Anemia, Sickle Cell, Birth Defects, Asthma, Smoking, Drugs, Obesity or Cancer**

LIVING RELATIVES & AGE	SPECIFY CHRONIC ILLNESS(ES)
Grandfather (maternal)	
Grandmother (maternal)	
Grandfather (paternal)	
Grandmother (paternal)	
Father	
Mother	
Sibling(s)	

DECEASED RELATIVE & AGE AT DEATH	CAUSE OF DEATH
Grandfather (maternal)	
Grandmother (maternal)	
Grandfather (paternal)	
Grandmother (paternal)	
Father	
Mother	
Sibling(s)	

ALLERGIES

Please list any medication allergies:

Please list anything other allergies:

MEDICAL HISTORY: (Please circle Yes or No) **If Yes, Please explain:**

1. Has your child ever been hospitalized? Yes No
2. Has your child ever had surgery? Yes No
3. Has your child ever had a repeated illness? Yes No
4. Has your child ever had a complicated illness? Yes No
5. Has your child ever been allergic to anything? Yes No
6. Has your child ever had a reaction to any medication? Yes No
7. Is your child on regular medications? Yes No
8. Is your child behind on immunizations? Yes No
9. Does anyone in the home smoke? Yes No
10. GIRLS ONLY: Have you started your menstrual cycle? Yes No
    If yes, What age did you start? _____
    If yes, Date of last menstrual period: _____

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GENERAL MEDICAL HISTORY

ILLNESSES: Please circle any of the following illnesses that your child has had:

Anemia	Blood Transfusions	Bone Disease/Spine Curvature
Hernia	Bleeding Disorders	Back Trouble
Frequent Headaches	High Blood Pressure	Drug Reaction
Diabetes	Asthma or Hay Fever	Convulsion
Painful Urination	Kidney Stones	Ear Disease (More than 3 ear infections)
Ulcer	Skin Disease	Allergies
Cancer	Pneumonia	Heart Disease
Heart Murmur	Repeated or Severe Sprains	Other: _____

MEDICATION: Is your child on any medications? If yes, please list below:

1.
2.
3.
4.
5.

HOSPITALIZATION: Please list any hospitalizations you have had (excluding childbirth)

Year	Diagnosis	Hospital (City and State)

SURGERY: Please circle any operations you have had on any of the following

Appendix	Kidney	Breast
Tonsils	Tumor	Chest
Heart	Hernia	Other:

IMMUNIZATIONS: Please list the date of your last immunization record OR Provide a copy of current immunization record

Tetanus (Tdap) _____	HPV (Gardasil) _____	Influenza _____
MMR _____	Varicella (Chicken Pox) _____	Hepatitis B _____

University Medical Associates of Aiken

Authorization to Disclose Health Information

Patient's Name: _____ Date of Birth: _____

I, _____, authorize

University Medical Associates of Aiken to obtain, disclose and or use the following health information.

____Progress Notes	____Referral Letters
____Labs/X-Rays	____Patient History/Physicals
____Immunization Record	____Discharge Summaries
____Medication List	____Entire Medical Record

Medical Records From: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

Purpose for this release: _____Medical Care _____Other (please specify:_____)

I understand that my health information in my record may include information about sexually transmitted disease, human immunodeficiency virus (HIV), or acquired immunodeficiency syndrome (AIDS). Behavior or mental health information and the treatment for drug and/or alcohol abuse may be included in the health information.

I understand that authorizing the disclosed health information is voluntary and I may at anytime cancel the disclosure of health information. I understand that I may obtain a copy of my health record that may be used. I understand that any disclosure of information carries the potential for an unauthorized re-disclosure and the information may not be protect by state or federal privacy rules.

This health information may be disclosed to and used by the following health care providers by mail or fax:

University Medical Associates of Aiken
5110 Woodside Executive Court
Aiken, SC 29803
Phone: 803-643-0588 Fax: 803-643-1776

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Signature of Witness Relationship