Palmetto Family Medicine & Senior Care, LLC

NEW PATIENT REGISTRATION FORM

Last Name:	First Name:	MI:

I am a patient of (circle one): Dr. William Long or Dr. John Ropp

Preferred Pharmacy: (This will be used to electronically send your prescriptions when possible):	**Consent to share medical history (including medications, history, etc.): Please check box below:**
Name: ____________________	☐ Yes
Location: _________________	☐ No

RESPONSIBLE PARTY INFORMATION (if other than patient)

(*To be completed if responsible party is someone other than the patient (i.e. minor child, legal guardian)

Relationship to Patient:		
Last Name:	First Name:	MI:
Address:	City/State:	Zip:
Primary Phone:	DOB:	SSN:

PRIMARY INSURANCE INFORMATION

Insurance Name:	
Policy ID:	Group ID:
Policy Holder Last Name:	First Name:
Policy Holder DOB:	Policy Holder SSN:
Employer:	

SECONDARY INSURANCE INFORMATION

Insurance Name:	
Policy ID:	Group ID:
Policy Holder Last Name:	First Name:
Policy Holder DOB:	Policy Holder SSN:
Employer:	

EMERGENCY CONTACT

Name:	Relationship:	Phone:

Patient/Legal Guardian Signature ______________________________ Date______

Consent for Treatment, Assignment of Benefits, Release & Financial Policy

Thank you for choosing Palmetto Family Medicine and Senior Care to meet your medical needs. We are dedicated to providing the best treatment available.
*Carefully read and initial each section and sign and date the bottom.

- I voluntarily consent to any and all healthcare treatment and diagnostic procedures provided by PFMSC and its associated physicians, clinicians and other personnel. I am aware that the practice of medicine and other healthcare 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 treatments or examinations at PFMSC. **INITIALS ___________**

Assignment of Benefits and Release of Information

- I hereby authorize treatment of myself or the minor named on this application. I hereby authorize PFMSC to release medical information to facilitate payment and coordination of care for rendered services. I authorize payment from my insurance company to be assigned to PFMSC. I understand that I am ultimately responsible for the balance of my account.
- I authorize the release of all medical information necessary for PFMSC to meet State and Federal reporting requirements. If receiving medical services for employment, I authorize the release of the results of my exam to my employer.
- I authorize PFMSC to obtain all of my medication/prescription history when using an electronic system to prescribe medications. I acknowledge that I retain the right to review PFMSC Notice of Privacy Practices in the office upon request. **INITIALS ___________**

Designated Party Release

You may give PFMSC written authorization to disclose your protected health information to anyone that you designate. If you wish to authorize a person to receive your protected health information, please indicate below. You may also indicate how you would prefer for our office to communicate with you concerning your lab and test results, prescription refills, and appointment reminders.

- **I authorize PFMSC to disclose my Protected Health Information (PHI) to the following individuals:**
  Name: ________________________________ Phone:_______________________

  Name: ________________________________ Phone:_______________________

  Name: ________________________________ Phone:_______________________

- **I authorize PFMSC to communicate my Protected Health Information to me via the following methods:**
  - ☐ **MedBook (electronic health record)- received via email/text**
  - ☐ **Home Phone: _______________________**
  - ☐ **Cell phone voicemail: _________________**

Authorized signature: ____________________________ Date: ______________

FINANCIAL POLICY

Missed Appointments: A missed appointment fee of $50 will be charged for any missed appointment that is not canceled within 24 hours of the scheduled appointment. This fee must be paid before a new appointment is scheduled. You may be discharged from PFMSC if you have more than three missed appointments.

INITIALS ______________

Account Balances: Patient account balances are due within 30 days of the receipt of the billing statement and must be paid prior to services being rendered. If you are unable to pay your balance in full, we will reschedule your appointment until arrangements have been established. If you have failed to make appropriate payment arrangements after two billing statements, your account may be turned over to an outside collection agency. Accounts assigned to Collections may be charged a $50 fee and/or discharged from this practice. If this is to occur, you will be notified that you have 30 days to find alternative care. During that 30-day period, our physicians will only be able to treat you on an emergency basis.

INITIALS ________________

Returned Checks: A $35 returned check fee plus your balance is due when you are notified of a returned check.

INITIALS ________________

Self-pay patients and patients who have not met their deductible are required to pay for services in full prior to leaving. It is your responsibility to inform us in a timely manner of any changes to your billing and insurance information. If an insurance company denies payment for incomplete or wrong information, it is your responsibility to make payment in full. Please be aware there is a time limit on how long we have to file insurance claims. If we miss the deadline because you did not provide us with the correct information, you will be responsible for payment in full. We request your assistance in following up with your insurance company to resolve any non-payment issues. It is your responsibility to pay the bill. Please be aware that some and perhaps all of the services you receive may be non-covered by Medicare or other Insurers. You are responsible for any and all portions of the bill not covered by your insurance plan. You must pay for these services in full at the time of visit. **Co-pays must be paid prior to services being rendered.** Your insurance company may deny the claim if co-pays are not collected, and you may be responsible for the entire charge. To prevent this, if you are unable to pay your co-pay, we will have to reschedule your appointment. Deductibles and co-insurance fees must be paid at check-out. Patients who are unable to pay for the services as required by their insurance will be required to speak with an account representative to set up a payment plan.

INITIALS: ________________

Signature of Patient or Responsible Party: _________________________ Date: _____________

Palmetto Family Medicine and Senior Care

New Patient Medical History

Please fill out the form completely. The following information will help us to provide you with the best medical care and treatment possible.

Patient Name ________________________________ Date of Birth _________________

Highest level of education: ____________________ Occupation: ______________________

List any known allergies and reactions: ____
____

- ☐ Latex Allergy
- ☐ Adhesive Allergy

Personal Medical History: (Check any that apply.)

- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Diabetes
- ☐ Seizures
- ☐ Mental Health Issues
- ☐ Asthma
- ☐ Depression
- ☐ Stroke
- ☐ Hypothyroidism
- ☐ Cancer

Type of Cancer: __________________

Surgeries:

- ☐ Appendix
- ☐ Tonsils/Adenoids
- ☐ Gallbladder
- ☐ Heart

Other: ____
____

Women:

- ☐ Pregnant
- ☐ Abnormal PAP
- ☐ C-Section
- ☐ Hysterectomy

Last Menstrual Cycle _________

Last PAP Smear _____________

# of Pregnancies _____________

# of Live Births _____________

Social History:

- ☐ Do you smoke? How long does one pack last you? _________
- ☐ Marijuana Usage?
- ☐ Do you drink alcohol? How often? ________________________
- ☐ Any other forms of tobacco? List: ______________________________
- ☐ Other Illicit drug use?

Family Medical History:

- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Diabetes
- ☐ Seizures
- ☐ Mental Health Issues
- ☐ Asthma
- ☐ Depression
- ☐ Stroke
- ☐ Hypothyroidism
- ☐ Cancer

Type of Cancer: __________________