New Patient Info Packet

Carolina Medical
PARTNERS

THANK YOU for Choosing Carolina Medical Partners!

Helpful information before your first appointment:

» Our practice is located at 1028 Edgewater Corporate Pkwy. (Suite 103) in Indian Land, SC.

» Please be sure this new patient info packet is filled out as completely as possible.

» Please bring a current list of your medications, as well as any immunization records you may have.

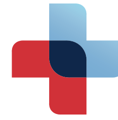
» Please be sure to arrive at least 15 minutes prior to your scheduled appointment. We need time to enter your information into the system before your provider can see you.

» Please bring a valid photo ID and your insurance card (if you will be using your health insurance).

» Co-payments, deductibles, co-insurances, and all other costs are due at the time of service.*

**Please ask to speak with a member of our billing staff if you are unable to make payment at the time of your visit.*

New Patient Form



Carolina Medical
PARTNERS
1028 Edgewater Corporate Pkwy, Suite 103
Indian Land, SC 29707
Phone: 803.547.8660 **Fax:** 803.650.3880
info@carolinamedicalpartners.com

Patient General Information (Please Print)

Name: ______________________ DOB: ______________ Sex: ☐ M ☐ F

Social Security #: ______________ Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Race: ☐ White ☐ Black ☐ American Indian ☐ Asian ☐ Hispanic ☐ Other: ______________

Primary Address: ______________________ State: ______ Zip: __________

Home Phone: ______________ Work Phone: ______________ Cell Phone: ______________

Email: ______________________ Authorize Email?: ☐ Yes ☐ No

Preferred Contact Method: ☐ Home ☐ Work ☐ Cell ☐ Email

Emergency Contact: ______________ Relationship: __________ Phone: __________

Pharmacy: ______________ Phone: __________ Fax: __________

Pharmacy Address: ______________________

Employment Status: ☐ Employed ☐ Not Employed ☐ Retired ☐ Student

Employer: ______________ Occupation *(if student, please specify)*: ______________

How did you hear about us?: ☐ Insurance ☐ Doctor ☐ CMP Website ☐ Internet/Social Media ☐ Friend/Family ☐ Other

Insurance Information

Primary Insurance

Insurance Name: ______________ Subscriber's Name: ______________

Insurance ID#: ______________ Group #: ______________

SSN: __________ DOB: __________ Relationship to Insured: ______________

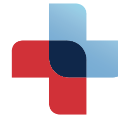
Secondary Insurance

Insurance Name: ______________ Subscriber's Name: ______________

Insurance ID#: ______________ Group #: ______________

SSN: __________ DOB: __________ Relationship to Insured: ______________

Patient Communication & Records Release



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Appointment Reminder Consent

I wish to be reminded of upcoming appointments via: ☐ Home Ph. (call/leave msg) ☐ Cell Ph. (call/leave msg) ☐ Text ☐ Email

Authorization to Release Medical Information

In the event you must be contacted in regards to test results/medical information, appointment reminders, referrals, or other reasons, please indicate how you would like to be contacted (check all that apply):

☐ PHONE Preferred Phone: ☐ Home ☐ Work ☐ Cell ☐ Other *(please specify)*: ______________________

☐ MAIL Primary Address *(if different than listed on the New Patient Form)*: ______________________

☐ EMAIL Preferred Email *(if different than listed on the New Patient Form)*: ______________________

Patient Phone Message Consent

Our policy is to notify patients via phone of office-ordered test results, medical appointment confirmations and other items realted to your visit with us. This is to acknowledge that you authorize Carolina Medical Partners to:

Leave a detailed message on your voicemail/answering machine/cell .... YES ________ NO ________ *(initial yes or no)*

Leave a detailed message with an individual answering the phone .... YES ________ NO ________ *(initial yes or no)*

If you selected yes to the above, please provide the name of all individuals with whom we can leave a message with:

Name: ______________________ Relationship: ______________ Phone #: ______________________

Name: ______________________ Relationship: ______________ Phone #: ______________________

Sharing of Medical & Financial Information

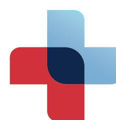
I give the physician and office staff of Carolina Medical Partners permission to discuss my medical condition/financial information with the following individuals:

Name: ______________________ Relationship: ______________ Phone #: ______________________ ☐ Medical ☐ Financial

Name: ______________________ Relationship: ______________ Phone #: ______________________ ☐ Medical ☐ Financial

Name: ______________________ Relationship: ______________ Phone #: ______________________ ☐ Medical ☐ Financial

Patient Authorizations



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Patient Authorization for ePRESCRIBE

ePrescribing is a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy from the practice. ePrescribing greatly reduces medication errors and enhances patient safety. Understanding all of the above, I hereby authorize the physician and/or staff of Carolina Medical Partners to enroll me in the ePrescribe Program.

Patient's Signature: ________________________________ **Date:** ______________

Patient Authorization for PHARMACY BENEFITS

I authorize the physician and/or staff of Carolina Medical Partners to request and obtain my prescription medication history from other healthcare providers, the pharmacy benefit manager, and/or any third party pharmacy payors for treatment purposes.

Patient's Signature: ________________________________ **Date:** ______________

Patient Authorization for MEDICARE PATIENTS

I authorize the physician and/or staff of Carolina Medical Partners to release to the social security administration, Health Care Financing Administration or its intermediaries or carriers any information needed for this or any 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 to the party who may cause Medicare payment information to cross over automatically to my supplement insurer. I understand that I am financially responsible for any services deemed non-covered by Medicare.

Patient's Signature: ________________________________ **Date:** ______________

Patient Authorization for PPO & HMO PATIENTS

I authorize the physician and/or staff of Carolina Medical Partners to release to my insurance company or its representative any information including the diagnosis and records of any treatment or examination rendered to me during medical or surgical care. I authorize and request my above named insurance company to pay directly to Carolina Medical Partners the amount due for medical or surgical services. I understand that I am financially responsible for any services deemed non-covered by my insurance.

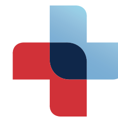
Patient's Signature: ________________________________ **Date:** ______________

Patient Authorization for ALL PATIENTS

I understand that I am financially responsible for services in the office and that refunds from services charged on a credit card will be returned to the same credit card. Furthermore, I also understand that any account balance that is not paid may be sent to a collection agency. Should any delinquent account balance be referred to a collection agency, I understand that I will be financially responsible for any and all cost and fees relating to the collection of my debt. I also authorize my physician and Carolina Medical Partners to photograph me for medically related documentation purposes.

Patient's Signature: ________________________________ **Date:** ______________

Patient Consent



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Patient Consent to Treat

I hereby give my consent to Carolina Medical Partners and authorize him or her to provide my medical treatment. I understand that Carolina Medical Partners will explain my condition(s), foreseeable risks, and methods of treatment for my condition before treatment is provided. I authorize Carolina Medical Partners to perform any additional or different treatment that is thought necessary if, in an emergency situation, a condition is discovered that was not known previously.

I have carefully read and I fully understand this Patient Consent to Treat form and have had the opportunity to discuss my condition and the above procedure(s) with the care provider. All my questions have been adequately answered.

Patient's Signature: ______________________________ **Date:** ________________

Patient Consent for Use & Disclosure of Protected Health Information

With your consent, Carolina Medical Partners may use and disclose protected health information (PHI) about you to carry out treatment, payment and healthcare operations (TPO). You have the right to review our Notice of Privacy Practices prior to signing this contract. We reserve the right to revise our Notice of Privacy Practices at any time.

With your consent, Carolina Medical Partners may call, email or send mail to your home or office and leave a message about any items that assist the practice in carrying our TPO such as appointment reminders, insurance items and any call pertaining to your clinical care.

You have the right to request that we restrict how we use or disclose your PHI to carry out treatment, payment and health care operations. However, we are not required to agree to your requested restrictions, but if we do, we are bound by our agreement.

By signing this form, you are consenting to our use and disclosure of your PHI to carry out treatment, payment and health care operations. This consent may be revoked in writing except to the extent that we may have already made disclosures in reliance upon your prior consent.

If you decline to sign this consent, we may decline to provide treatment for you.

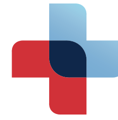
________________________________ ________________________________

Patient's Printed Name **Signature of Patient or Legal Guardian**

________________________________ ________________________________

Relationship to Patient *if other than self* **Date**

Cancellation Policy



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Cancellation & No Shows

Our policy is as follows: Non-Cancellation/No Shows within 24 hours notification = $30.00

Patients who do not show up for their appointment without a call to cancel an office appointment or procedure appointment will be considered as a NO SHOW. Patients who no-show three (3) or more times in a 12 month period, may be dismissed from the practice and will be denied any future appointments.

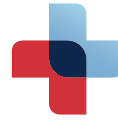
The Cancellation and No Show fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment. We understand that special unavoidable circumstances may cause you to cancel within 24 hours. Fees in this instance may be waived, but only with management approval.

Our practice firmly believes that good physician/patient relationship is based upon understanding and good communication.

I acknowledge that I have read and understand Carolina Medical Partners Cancellation Policy.

Patient's Signature: ______________________________ **Date:** ______________

Health History Form



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Medical History

(Check all that apply)

	AGE		AGE		AGE
☐ ADD/ADHD	______	☐ Diabetes	______	☐ Rheumatologlc Disease	______
☐ Anemia	______	☐ Depression	______	☐ Seizures	______
☐ Anxiety	______	☐ Emphysema	______	☐ Stroke	______
☐ Arthritis	______	☐ Erectile Dysfunction	______	☐ Substance Abuse	______
☐ Asthma/Allergies	______	☐ Fibromyalgia	______	☐ Other *(specify below)*:	
☐ Atrial Fibrillation	______	☐ Gallstones	______	______________________________	
☐ Blood Clot	______	☐ Gout	______	______________________________	
☐ High Blood Pressure	______	☐ Heart Attack	______	______________________________	
☐ Cancer	______	☐ Heartburn/Reflux	______	______________________________	
☐ High Cholesterol	______	☐ Kidney Disease	______	______________________________	
☐ COPD	______	☐ Liver Disease	______	______________________________	

Immunizations *(date)*: Tetanus ______ HPV ______ Pneumonia ______ Shingles ______ Hepatitis B ______ Meningitis ______

SERIOUS INJURIES, ILLNESSES OR HOSPITALIZATIONS *(please provide age)*: ______________________________

____

OPERATIONS / MAJOR SURGERIES *(please provide age)*: ______________________________

____

No. of Pregnancies: ______ No. of Live Births: ______ No. of Living Children: ______ Pregnancy Complications? __________

Last Pap: ____________ Abnormal Pap Test? ☐ Y ☐ N Last Mammogram: ____________ Contraception: ____________

RECENT MEDICATIONS & DOSAGES *(including laxatives, antacids and aspirin)*: ______________________________

____

ALLERGIES *(medications, pollens, foods, etc)*: ______________________________

____

How often do you exercise?: ________ per ____________ How long do you exercise for?: __________ mins / hrs *(circle one)*

What are your hobbies?: ____

How is your sleep?: ☐ Very Poor ☐ Poor ☐ Fair ☐ Good ☐ Excellent Comments: ______________________

How is your diet?: ☐ Very Poor ☐ Poor ☐ Fair ☐ Good ☐ Excellent Comments: ______________________

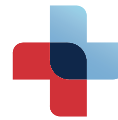
Alcohol Intake *(avg # of drinks per day)*: ______ Recreational Drug Use *(include type and age)*: ______________________

Ever smoked? ☐ Y ☐ N How long?: ____________ How much?: __________ Tried Stopping? ☐ Y ☐ N Quit Date: ________

Education *(highest level completed; special studies)*: ______________________________________

Special problems related to home or work conditions: ______________________________________

Health History Form cont...



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Family History

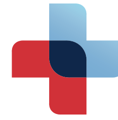
Check if anyone in your family has ever had the following:

	Relationship		Relationship		Relationship
☐ Diabetes	____________	☐ Stroke	____________	☐ Gout	____________
☐ High Blood Pressure	____________	☐ Migranes	____________	☐ Asthma	____________
☐ Anemia	____________	☐ Obesity	____________	☐ Arthritis	____________
☐ Heart Disease	____________	☐ Thyroid Disease	____________	☐ Mental Illness	____________
☐ Cancer	____________	☐ Elevated Cholesterol	____________	☐ Allergies	____________
☐ Bleeding Disorder	____________	☐ Kidney Disorder	____________	☐ Other: ____________	

	IF LIVING		IF DECEASED	
	Age	State of Health	Age	Cause of Death
Mother	_____	______________	_____	______________
Father	_____	______________	_____	______________
Brother(s)	_____	______________	_____	______________
Sister(s)	_____	______________	_____	______________
Spouse	_____	______________	_____	______________
Children	_____	______________	_____	______________

Please use the bottom half of this page if you need more space to detail your answers.

Rights & Responsibilities



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You Have a Right:

- To be treated with respect, consideration and dignity always.
- To receive assistance in a responsible manner
- To receive Information about your health including your diagnosis, treatment, testing or procedures and medical alternatives including associated risks that may be involved in your healthcare.
- To know the identity and professional status of individuals providing services to you.
- To expect that your medical records and communications will be treated in a confidential manner.
- To refuse treatment and be advised of the alternative and likely consequences of your decision.
- To express a complaint to the Administrator, and/or Physician.

You Have a Responsibility:

- To review and understand your health insurance coverage and benefits.
- To learn and understand the proper use of your insurance plan services and procedures for obtaining coverage.
- This includes knowing the referral policy for your plan, laboratory restrictions and outpatient facilities covered by your plan as well as co-pay requirements.
- To always carry your insurance plan identification card and be prepared to show it at each visit. If asked.
- Patients will be required to pay for all services provided if insurance information is not provided by the patient at the time services are rendered or the information provided is inaccurate.
- To treat all office personnel respectfully and courteously.
- To keep scheduled appointments and to notify the office promptly if you will be delayed or unable to keep an appointment.
- To pay all charges for co-payments, deductibles, non-covered benefits or services at the time of your visit, unless prior arrangements have been made.
- To ask questions and seek clarification until you fully understand the care you are receiving.
- To follow the advice of your medical provider and consider the alternatives and/or likely consequences if you refuse to comply.
- To provide honest and complete information to those providing medical care.
- To express your opinions, concerns, or complaints in a constructive and appropriate manner.

______________________________ ______________________________
Patient's Printed Name **Signature of Patient or Legal Guardian**

______________________________ ______________________________
Relationship to Patient *if other than self* **Date**