PATIENT'S PERSONAL INFORMATION

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed **Sex:** ☐ Male ☐ Female

Name: ______________________ (last name) ______________________ (first name) ________ (initial)

Home Phone: (_____) ______________ **Work Phone:** (_____) ______________ **Cell Phone:** (_____) ______________

Address: ______________________ **Apt. #:** ______ **City:** ____________ **State:** ____ **Zip:** __________

Date of Birth _____ - ________- ________ **Social Security** __________- __________- ________ **Email Address** ______________________

Ethnicity ______________ **Primary Language** ______________ **Race** __________ **Can we leave a message if results are normal? YES NO**

PATIENT 'S / RESPONSIBLE PARTY INFORMATION

Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other: ______________

Name: ______________________ (last name) ______________________ (first name) ________ (initial)

Date of Birth: _______ / _______ / _______ Social Security #: _______ - _______ - _______

Home Phone: (_____) ______________ Work Phone: (_____) ______________ Cell Phone: (_____) ______________

Address: ______________________ Apt. #: ______ City: ____________ State: ____ Zip: __________

PATIENT'S INSURANCE INFORMATION

Please present insurance cards to receptionist.

PRIMARY Insurance Name: ______________________________ **If Medicare is 2nd please list reason below**

Address: ______________________ City: ____________ State: ____ Zip: __________

Name of insured: ______________________ Date of Birth: __________ Relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Policy #: ______________________ Group #: ______________________ Copay: $ __________

SECONDARY Insurance Name: ______________________________

Address: ______________________ City: ____________ State: ____ Zip: __________

Name of insured: ______________________ Date of Birth: __________ Relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Policy #: ______________________ Group #: ______________________ Copay: $ __________

PATIENT'S REFERRAL INFORMATION

How did you hear about our practice? Patient Specialist Newspaper Magazine other

Name: ______________________ Phone (______) ______________ Fax (______)______________

Address: ______________________ City: ____________ State: ____ Zip: __________

PHARMACY INFORMATION

Name: ______________________________

Address: ______________________ City: ____________ State: ____ Zip: __________

Phone: (_____) ______________ Fax: (_____) ______________

EMERGENCY CONTACT

Name: ______________________ Relationship: ______________________

Address: ______________________ City: ____________ State: ____ Zip: __________

Home Phone: (_____) ______________ Work Phone: (_____) ______________ Cell Phone: (_____) ______________

Assignment of Benefits • Financial Agreement

I hereby give lifetime authorization for payment of insurance benefits to be made directly to Palmetto Medical Group, and any assisting physicians for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default I agree to pay all costs of collections, and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

Date: ______________ Signature: ______________________________

Allergies ____________________ ____________________
____________________ ____________________

Medication List

Name ______________________________ **DOB** ______________________

Please list all medication as directed below:

Medication Name	Dosage/Directions

Past Medical History

Patient Name ____________ *DOB*________ *Date*________

Allergies ____________________ ____________________

____________________ ____________________

Cardiovascular
- ☐ Atrial Fibrillation
- ☐ Arterial Clot
- ☐ Carotid Artery Disease
- ☐ Congestive Heart Failure
- ☐ Coronary Artery Disease
- ☐ Deep Vein Thrombosis
- ☐ High Cholesterol
- ☐ Hypertension
- ☐ Heart Attack
- ☐ Peripheral Vascular Disease
- ☐ Heart Valve Disease
- ☐ Other:

Pulmonary
- ☐ Asthma
- ☐ Chronic Bronchitis
- ☐ COPD
- ☐ Pneumonia
- ☐ Pulmonary Embolism
- ☐ Pulmonary Hypertension
- ☐ Sarcoidosis
- ☐ Sleep Apnea
- ☐ Other:

Gastrointestinal
- ☐ Gall Stones
- ☐ Cirrhosis
- ☐ Colon Polyps
- ☐ Crohn's Disease
- ☐ GERD
- ☐ Hepatitis
- ☐ Irritable Bowel Syndrome
- ☐ Pancreatitis
- ☐ Peptic Ulcer Disease
- ☐ Ulcerative Colitis
- ☐ Other:

Renal/Urology
- ☐ Acute Renal Failure
- ☐ Benign Prostatic Hypertrophy
- ☐ Chronic Renal Failure
- ☐ Endometriosis
- ☐ Erectile Dysfunction (Impotence)
- ☐ Glomerulonephritis
- ☐ Infertility
- ☐ Polycystic Kidney Disease
- ☐ Kidney Stones
- ☐ Urinary Incontinance
- ☐ Frequent Bladder Infections
- ☐ Vesicoureteral Reflux
- ☐ Other:

Musculoskeletal/Connective tissue
- ☐ Chronic Pain
- ☐ Fibromyalgia
- ☐ Fractures
- ☐ Gout
- ☐ Osgood-Schlatter Disease
- ☐ Osteoarthritis
- ☐ Paget's disease
- ☐ Polymyalgia Rheumatica
- ☐ Rheumatoid Arthritis
- ☐ Sjogren's Disease
- ☐ Slipped Capital Femoral Epiphysis
- ☐ Systemic Lupus Erythematosis

Endocrine
- ☐ Addison's Disease
- ☐ Carcinoid Syndrome
- ☐ Cushing's Disease
- ☐ Diabetes Type I
- ☐ Diabetes Type II
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Osteoporosis/Osteopenia
- ☐ Other:

Neurological
- ☐ Alzheimer's Disease
- ☐ ADD/ADHD
- ☐ Cerebral Palsy
- ☐ Dementia
- ☐ Degenerative Disc Disease
- ☐ Headaches
- ☐ Parkinson's Disease
- ☐ Sensory Neuropathy
- ☐ Seizures
- ☐ Stroke
- ☐ TIAs
- ☐ Other:

Hematologic
- ☐ Hemolytic Anemia
- ☐ Iron Deficiency Anemia
- ☐ Myelofibrosis
- ☐ Pernicious Anemia
- ☐ Sickle Cell Disease
- ☐ Thallesemia

List any Allergies:

____

____

____

Cancers, please list:

____

____

____

Other
- ☐ Cataract
- ☐ Glaucoma
- ☐ Over Weight
- ☐ _______________
- ☐ _______________

Psychiatric
- ☐ Anxiety
- ☐ Anorexia Nervosa
- ☐ Bipolar Disorder
- ☐ Bulimia
- ☐ Depression
- ☐ Obsessive Compulsive
- ☐ Schizophrenia

Do You See Any Specialists? ☐ **No** ☐ **Yes** (indicate below)

Dr. ______________________ for ___________________ Dr. ______________________ for ___________________

Dr. ______________________ for ___________________ Dr. ______________________ for ___________________

Patient Name ____________ DOB _______Date_______

Surgical History – Adult

Surgeon	Surgery	Date	

Family History

Relation	Medical Problems	Age at Death	Cause of Death
Father			
Mother			
Brothers #			
Sisters #			
Sons #			
Daughters #			

Pregnancy/Gynecological History

Pregnancies # _________
Children # _________
Abortions # _________
Miscarriages # _________

☐ Pregnancy Problems
☐ Menstrual Problems

Current Birth control ________
Age Periods Started _________
Last Pap Smear __________

Last Mammogram _________
Age at Menopause __________

Social History - Adult

Occupation ______________

Employer _______________

Prior job if retired:
____

Marital Status
☐ Single
☐ Married
☐ Separated
☐ Divorced
☐ Widowed

Number of Children ______

Hobbies ________________

Exercise (type): ___________
☐ Never
☐ Rarely
☐ __ times/week
☐ Daily

Caffeine: _______ drinks/day

Tobacco:
☐ Never
☐ In past, quit date ______
☐ Cigarettes
#packs/day _____
☐ Cigars, #/day ____
☐ Smokeless

How often do you use alcohol?
☐ None
☐ Rare
☐ Social
☐ Regular
#drinks/week ____
☐ Occasional Binge
☐ Current alcoholic
☐ Past alcoholism

Illicit Drugs:
☐ Yes
☐ No
☐ In past

Are you taking any herbals or supplements?
☐ Yes
☐ No

Are you currently dieting?
☐ Yes
☐ No

Patient Name ____________ DOB _______Date_______

Please provide dates your received service/test/screening listed below.

- Abdominal Aortic Aneurysm Screening (abdominal U/S) _________________
- Bone Mass Measurement (Bone Density) _________________
- Cardiovascular Screenings (EKG & stress test) _________________
- Colorectal Cancer Screenings (any of the 4)
  - Fecal Occult Blood Test _________________
  - Flexible Sigmoidoscopy _________________
  - Colonoscopy _________________
  - Barium Enema _________________
- Diabetes Screenings (blood sugar test) _________________
- Diabetes Self-management Training _________________
- Flu Shots _________________
- Glaucoma Tests (Eye Exam) _________________
- Hepatitis B Shots _________________
- HIV Screening _________________
- Mammogram (screening) _________________
- Diet Counseling _________________
- Pneumococcal Shot (pneumonia) _________________
- Prostate Cancer Screenings (PSA) _________________
- Smoking Cessation _________________
  (Counseling to stop smoking for people with no sign of disease)
- Pap Test and Pelvic Exam (includes breast exam) _____________

Financial Policy

Thanks for choosing our office for your medical care. Please understand that payment of your bill is considered a part of your treatment.

- Co-payments and deductibles are to be paid at each appointment as services are rendered. If you have a high deductible plan, a payment of $75.00 will be required prior to being seen. For the convenience of our patients, we accept cash, personal checks, American Express, Master Card, and Visa. * Our office does not accept post-dated checks*
- Medical Insurance- We strongly urge you to thoroughly review your insurance plan guidelines/booklet prior to your appointment. Although we may be contracted with your insurance accompany, your particular type of plan could exclude some services. In the event the insurance company does not pay for services rendered, the balance will become the patient's responsibility and will be billed directly to you. Balances unpaid by your insurance company will be billed to you and must be paid within thirty (30) days.
- We recognize that under unusual circumstances an account balance may be incurred. Palmetto Medical Group requires that all outstanding balances be paid in full; within thirty (30) days unless other arrangements have been made.
- **Accounts not paid within 30 days of the date of the invoice are subject up to a $25 late fee**. Also note, if we have not received payment or you have not contacted us in thirty (30) days, further action may be taken with a collection agency and termination from the practice.

Thank you in advance for your understanding of our financial Policy.

______________________________ ______________________________

Patient/Guardian signature **Date**

Appointment Policy

We pride ourselves in providing extra time for personal attention each patient deserves. We respect your time and make every effort to keep you from waiting. We request you provide us with at least 24 hours notice if you need to reschedule your appointment. If this notice is not given, a $25 fee will be charged to your account for missed office visits and/or $75.00 for missed radiology appointments.

We strive to provide our patients with the best care possible. Therefore, late arrivals cause schedule delays for those patients who arrive promptly at their appointment time. Late arrivals will be worked into the scheduled if time allows or rescheduled to another day. Please note, there will be a $25.00 fee for all rescheduled office visits and/or $75.00 for all rescheduled radiology appointments due to late arrival.

I have read and understand the above Office Policies and agree to abide by it contents:

______________________________ ______________________________

Patient/Guardian signature **Date**

FORMULARY BENEFITS DATA CONSENT FORM

Formulary Benefits data are maintained for health insurance providers by organizations known as Pharmacy Benefits Managers (PBM). PBM's are third party administrators of prescription drug programs whose primary responsibilities are processing and paying prescription drug claims. They also develop and maintain formularies, which are lists of dispensable drugs covered by a particular drug benefit plan.

By signing below I give permission for **Palmetto Medical Group, LLC** to access my pharmacy benefits data electronically through RxHub. This consent will enable **Palmetto Medical Group, LLC:**

Determine the pharmacy benefits and drug copays for a patient's health plan.

Check whether a prescribed medication is covered (in formulary) under a patient's plan.

Display therapeutic alternatives with preference rank (if available) within a drug class for non-formulary medications.

Determine if a patient's health plan allows electronic prescribing to Mail Order pharmacies, and if so, e-prescribe to these pharmacies.

Download a historic list of all medications prescribed for a patient by any provider.

In summary, we ask your permission to obtain formulary information, and information about other prescriptions prescribed by other providers using RxHub.

____ ____________________

Patient Name (PRINTED) Date of Birth

____ ____________________

Patient Signature Date

Acknowledgement of Receipt of Notice of Privacy Practices

I have been provided with a Notice of Privacy Practices that provides me a more complete description of the uses and disclosures of certain health information. I understand Palmetto Medical Group, LLC reserves the right to change their Notice of Privacy Practices and prior to implementation will provide an updated copy on the clinic website www.PamettoMedicalGrp.com, and in the physician's office. I may request a copy of the updated Notice of Privacy Practices by calling my physician's office or requesting a copy in person at my appointment.

______________________________ ______________________
Patient's Printed Name Date of Birth

______________________________ ______________________
Patient's or Legal Representative's Signature Date

____
Relationship to Patient

______________________________ ______________________
Witness Date

The following names are people I would like to be involved in or have access to my protected health information on a routine basis. I give permission for Palmetto Medical Group, LLC to share my protected health information with:

______________________________ – ______________________
Name Relationship

______________________________ – ______________________
Name Relationship

______________________________ – ______________________
Name Relationship

Sign up for text messages!

Receive appointment reminders on your cell phone.

It's easy to get these helpful texts!

Give us your cell phone #

Text palmetto to 622622

Cell # ______________________________

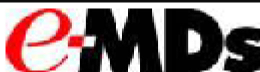
Sign up for the Patient Portal!

Access to YOUR health information...

Anytime

Anywhere

24-hour access to your personal health information and medical records!



Email: ______________________________

Confirmation email will be sent- please confirm within 48 hours after receiving.

https://www.healthportalsite.com/PalmettoMed

Please return completed form to front office

Scott Cummings, MD
Lynn Goetze, MD
Kamal Patel, MD
Stephanie Lovato, PA-C
Erica Roper, PA-C

If your physician has recommended you receive any of the following:

Routine Preventive Exam

Well-Woman Exam

Welcome to Medicare

Medicare Annual Wellness

We strongly urge you to review your insurance plan guidelines/booklet for the services above ***prior*** to your appointment, since your insurance contract in an agreement between you and the insurance company. There should also be a number on the back of your card for member services if you should need assistance determining your coverage.

PLEASE NOTE

****If this is NOT a covered service and you wish NOT to receive it, you must contact the office 24 hours in advance to cancel your appointment per our appointment policy.**

I understand that if I choose to receive these services and they are not covered, I will be responsible for payment in full. My signature below signifies I have read and received this document.

_______________________________ _______________________________

Patient Name Printed *Patient Signature*

_______________________________ _______________________________

Witness *Date*