Palmetto Internal Medicine & Primary Care, PA

PATIENT INFORMATION

Name (First)_____ (MI)_____ (Last)_____
Date of Birth _____ Sex: ☐ M ☐ F Marital Status: ☐S ☐M ☐W ☐D Driver License #_____
Street address_____
City, State, Zip_____
Home #_____ Cell #_____ Social Security #_____
Employer: _____ Employer Address: _____
Email Address: _____ If Student, School Name: _____ Full/Part Time: ____
In case of an Emergency, whom may we contact? _____ Phone # _____

RESPONSIBLE PARTY OR SPOUSE INFORMATION

Name: _____ Relationship to Patient: _____
Address: _____
City, State, Zip: _____
Home # _____ Social Security #_____ Date of Birth: _____
Work # _____ Employer: _____
Employers Address: _____
Friend or Relative Not Living With You: _____ Phone #: _____

INSURANCE INFORMATION

Insurance Company: _____ Phone # _____
Insurance Address: _____
Group # _____ Certificate or I.D _____
Insured Name: _____ Relationship to Patient: ☐ Self ☐ Spouse ☐ Dependent
Insured Employer: _____ Phone # _____
Employers Address: _____
Insured Social Security #: _____ Date Of Birth: _____ Sex: ☐ M ☐ F

SECONDARY INSURANCE (IF ANY)

Insurance Company: _____ Phone # _____
Insurance Address: _____
Group # _____ Certificate or I.D _____
Insured Name: _____ Relationship to Patient: ☐ Self ☐ Spouse ☐ Dependent
Insured Employer: _____ Phone # _____
Employers Address: _____
Insured Social Security #: Date Of Birth: Sex: ☐ M ☐ F

By signing below I agree that the above information is accurate to the best of my knowledge and is only for use in my treatment, billing and processing of insurance. I understand I am financially responsible for all charges that are not covered. understand that Palmetto Internal Medicine & Primary Care, P.A is not responsible for any errors or omissions that I may ha made in the completion of this form.

Patient Signature: _____ Date: _____

PALMETTO INTERNAL MEDICINE & PRIMARY CARE, PA
PROTECTED HEALTH INFORMATION

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

PATIENT NAME : _____

ADDRESS : _____

TELEPHONE # : _____ **E MAIL** : _____

SOCIAL SECURITY # : _____ **ACCOUNT:** _____

PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) , I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to

Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the Treatment directly or indirectly.

Obtain payment from third party payers and your insurance companies

Conduct normal healthcare operations such as quality assessment and physician certifications

I have been given a copy of Notice of Privacy Practices by Palmetto Internal Medicine & Primary Care, PA and been given the opportunity to read this notice before signing this consent. I understand that Palmetto Internal Medicine & Primary Care, PA has the right to change its Notice of Privacy Practices from time to time and that I may contact this facility at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand that the Palmetto Internal Medicine & Primary Care, PA is not required to agree to my requested restrictions, but if it does agree, then it is required to abide by these restrictions.

I understand that I have the right to revoke this Consent in writing at any time. I understand that revocation of this consent will not affect any action taken by Palmetto Internal Medicine & Primary Care, PA in reliance on this Consent before its revocation. I understand that Palmetto Internal Medicine & Primary Care, PA may decline to treat me or to continue to treat me this consent is revoked.

_____ _____

PATIENT SIGNATURE DATE

_____

RELATIONSHIP TO PATIENT

UNABLE TO OBTAIN PATIENT'S SIGNATURE / GUARDIAN'S SIGNATURE:

REASON : _____ DATE: _____

INITIALS_____

The Office for Civil Rights enforces the HIPAA Privacy Rule, which protects the privacy of individually identifiable health information; the HIPAA Security Rule, which sets national standards for the security of electronic protected health information; the HIPAA Breach Notification Rule, which requires covered entities and business associates to provide notification following a breach of unsecured protected health information; and the confidentiality provisions of the Patient Safety Rule, which protect identifiable information being used to analyze patient safety events and improve patient safety. http://www.hhs.gov/ocr/privacy/

Medical Information Release Form

(HIPAA Release Form)

Name: _____ **Date of Birth:** ____/____/____

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse_____

[ ] Child(ren)_____

[ ] Other_____

[ ] Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Messages

Please call [ ] my home [ ] my work [ ] my cell Number:_____

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] _____

The best time to reach me is (*day*)_____ between (*time*)_____

Signed: _____ Date: ____/____/____

Witness:_____ Date: ___/____/_____