

Patient Information

Please Print



Patient Demographics

Legal First Name	Legal Last Name	Suffix	Preferred First Name
Permanent Address	Apt. #	City	State Zip
Phone #	Social Security #	Gender	
Birth Date	Language	Marital Status	Email
Local or Alternate Address	Alternate Phone #	Today's Date	

Have you been treated at any Doctors Care before? Yes No

Emergency Contact Information

Contact Name	Contact Phone #
Contact Address	Apt. # City State Zip
Relationship to Contact	
Name of a Relative Not Residing With You	Relative's Phone #

Patient Employment Information

Employment Status	Employer		
Address	City State Zip		
Occupation	Employment Contact	Phone #	Fax

Responsible Party's Information

Responsible Party's Legal Name	Social Security #
Responsible Party's Address	Apt. # City State Zip Code

Medical Insurance Information Please present your Insurance Card and ID with this form.	PSR Notes:
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Policy Holder's Legal Name	Policy Holder's Social Security #			
Policy Holder's Address	Apt. # City State Zip			
Policy Holder's Phone #	Relationship to Policy Holder	Policy Holder's Birth Date	Gender	Policy Holder's Employer

How did you hear about us? Radio Friend Referral Phone Book Internet Sign Other

[PAT-F002-(9-08)]



Notice of Privacy Practices

Please Read and Sign

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

Patient Health Information

Under federal law, your patient health information is protected and confidential. Patient health information includes information about your symptoms, test results, diagnosis, treatment, and related medical information. Your health information also includes payment, billing and insurance information.

How we use your patient health information.

We use health information about you for treatment, to obtain payment, for administrative purposes, for evaluation of the quality of care, and so forth. Under some circumstances we may be required to use or disclose information even without your consent.

Treatment: We will use and disclose your health information to provide you with medical treatment or services. We may also disclose the information to other health care providers who are participating in your treatment, to pharmacists who are filling your prescriptions, to laboratories performing tests, and to family members who are helping with your care, and so forth.

Payment: We will use and disclose your health information for payment purposes. For example, we may need to obtain authorization from your insurance company before providing certain types of treatment. We will submit bills & maintain records of payments from your health plan.

Operation: We may ask you to complete a sign-in sheet or staff members may ask you the reason for your visit so we can better care for you. Despite safeguards, it is always possible in a doctor's office that you may learn information regarding other patients or they may inadvertently learn something about you. In all cases, we expect our patients to maintain strict confidentiality.

We may use and disclose your health information to perform various routine functions (e.g. quality evaluations or records analysis).

We may use your information to contact you. We may also contact you to provide information about referrals for follow-up with lab results, to inquire about your health or for other reasons.

We may share your information with Business Associates who assist us in performing routine operational functions but we will always obtain assurances from them to protect your information the same as we do.

Special Situations: We may be required by law to report gunshot wounds, suspected abuse or neglect, and so on; we may be required to disclose vital statistics, diseases, and similar information to public health authorities; we may be required to disclose information for audits and similar activities, in response to a subpoena or court order, or as required by law enforcement officials.

We may release information about you for worker's compensation or similar programs to protect your health or the health of others or for legitimate government needs, for approved medical research, or to certain entities in the case of death.

In some situations, we may ask for your written authorization before using or disclosing any identifiable health information about you. If you sign an authorization, you can later revoke the authorization.

Individual Rights

You have certain rights with regard to your health information, for example:

You may request restrictions on certain uses and disclosures of your health information. We are not required to accept all restrictions. If you pay in full for a treatment or service immediately, you can request that we not share this information with your medical insurance provider or our Business Associates. We will make every attempt to accommodate this request and, if we cannot, we will tell you prior to the treatment.

You may ask us to communicate with you confidentially by, for example, sending notices to a special address.

In most cases, you have the right to get a copy of your health information. There will be a charge for the copies.

If you believe information in your record is incorrect, or if important information is missing, you have the right to request that we amend the existing information.

You may request a list of instances where we have disclosed health information about you for reasons other than treatment, payment, or operations. The first request in a 12 month period is free. There will be charges for additional reports.

Our Legal Duty

We are required by law to protect and maintain the privacy of your health information, to provide this Notice about our legal duties and privacy practices regarding health information, and to abide by the terms of the Notice currently in effect.

We may update or change our privacy practices and policies at any time. Before we make a significant change in our policies, we will change our Notice and post the new Notice in the admissions area. You can also request a copy of our Notice at any time.

If you are concerned about your privacy rights, or if you disagree with a decision we made about your records, you may contact the person listed below. You also may send a written complaint to the U.S. Department of Health and Human Services. You will not be penalized in any way for filing a complaint.

Contact Person

If you have any questions, requests, or complaints, please contact:

Doctors Care
Attn: Ms. Kitty Howell
1600 Hwy 17 N.
Surfside Beach, SC
Email: kitty.howell@doctorscare.com

HIPAA South Carolina
US DHHS
Atlanta Federal Center
Suite 3B70
61 Forsyth Street
Atlanta, Ga. 30303-8909

Patient Acknowledgement

- I understand that a patient's health information is private and confidential. I understand that Doctors Care has procedures to protect a patient's privacy and preserve the confidentiality of every patient's personal health information. I will assist Doctors Care by following these procedures if I choose to exercise any of my rights described in the "Notice of Privacy Practices."
- This patient acknowledgement will become part of my permanent record. I further acknowledge that should I become aware of another patient's private health matters, I will not disclose them to others, and will treat any such knowledge as strictly confidential and private.
- My signature verifies that I understand how Doctors Care may use my patient information, that I have read the "Notice of Privacy Practices" and I agree to be seen and treated under stipulations as described.

Patient's Name

Date of Birth

Social Security

Signature

Witness

Today's Date

This notice describes the privacy practices of UCI Medical Affiliates, and its subsidiaries:
Doctors Care, Progressive Physical Therapy, Carolina Orthopedic & Sports Medicine, Luberoff Pediatrics, Doctors Wellness Center



Authorization for Release of Information

Patient Name: _____ DOB: _____

_____ is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

Entity to Receive Information. Check each person/entity that you approve to receive information.	Description of information to be released. Check each that can be given to person/entity on the left in the same section.
<input type="checkbox"/> Voice Mail _____	<input type="checkbox"/> Results of lab tests/x-rays _____
<input type="checkbox"/> Spouse (provide name & phone number) _____	<input type="checkbox"/> Financial <input type="checkbox"/> Medical as follows: _____
<input type="checkbox"/> Parent (provide name & phone number) _____	<input type="checkbox"/> Financial <input type="checkbox"/> Medical as follows: _____
<input type="checkbox"/> Other (provide name & phone number) _____	<input type="checkbox"/> Financial <input type="checkbox"/> Medical as follows: _____

Patient Information

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.

 Signature of Patient or Personal Representative

Date: _____

 Description of Personal Representative's Authority (attach necessary documentation)

Financial Policy and Disclosure

Please Sign and Date



The Financial Policy and Disclosure is to help us provide the most efficient and reasonable health care services. Therefore, it is necessary for us to have a Financial Policy and Disclosure stating our requirements for payment for services provided to patients.

Patients are responsible for the payment of all services provided by UCI Medical Affiliates, and its subsidiaries.

Self-Pay Policy

- If you are a self pay patient, you will be required to pay for the office visit before services are rendered
- In addition, any remaining balance on your account will be collected at discharge.

Insurance Policy

- If you are an insurance patient, it is our policy to file for insurance as a courtesy to you, if we have accurate and complete insurance information.
- If a service is provided that is not covered by your insurance company, you will be the responsible party at the time of service.
- If we have not received a payment from your insurance company within thirty (30) days, you will be responsible for the balance due.
- Deductibles, co-payments, and coinsurance will be collected before services are rendered.
- In special cases, we may need your help in contacting your insurance company for the payment of your services.

Workers Compensation Policy

- If you are a workers compensation patient, it is our policy to bill your employer or the worker's compensation carrier for services rendered.
- If you are covered under worker's compensation, we will accept the payments by the worker's compensation carrier as per contracted rates based on the mandated SC state fee schedule.
- If payment is denied from your worker's compensation carrier, you will become responsible for the entire balance of your services. Payment will be due within ten (10) days following any worker's compensation payment denial.
- It will be your responsibility to contact us with the name and address of your employer or the insurance company that covers your employer.

X-Ray Policy

- If you require an x-ray on today's visits, the x-ray will be sent out to a Radiologist for a second opinion for quality assurance purposes.
- You will be responsible for the cost of this service if your insurance company chooses not to cover it.

Over-due Balances

- All over-due patient balances **will be sent to collections**.
- All accounts sent to collections will be charged a \$25.00 collection fee in addition to the account balance.

To help in this policy we ask that you assist us by:

1. Providing us with current and updated information on yourself and your insurance company.
2. Presenting an updated photo identification card and insurance card when changes are made.
3. Making the appropriate payment at the time of service, whether it is a deductible, co-pay, coinsurance, or for the full amount if you are a Self-Pay Patient.

In order to provide the best medical care, we ask that you do not discuss your account balance or financial aspects with the physician(s) or medical staff. Please discuss any account information with the check out associate or front desk.

Responsible Party's Signature

Date



PLEASE READ - MEDICATIONS

In order to better serve you, Doctors Care has a medication program, which allows you to take home medications directly from our office.

- Our program allows you to fill your prescriptions while you are in our office (no waiting in lines at the pharmacy, no driving somewhere else)
- In most cases, our prices are comparable to your insurance co-pay or those offered at your local pharmacy (most of our medications are priced at \$15)

Please let us know if you are interested in having your prescriptions filled at Doctors Care.

_____ YES, I would like to purchase my medications from Doctors Care

_____ NO, I will get my medications filled at a pharmacy

_____ I may consider purchasing, but would like additional information

Patient/Legal Guardian Signature

Date