Patient Information and Consent

Please Print

What is the reason for your visit today? _____

Have you been treated at any Doctors Care office location before? ☐ **Yes** ☐ **No** - If "Yes" please complete line 1 (bolded) below, update any information that has changed since your last visit and sign the Patient Consent for Treatment section on page 2. Copy of insurance card is required for all visits.

Patient Information

Name (First, Middle, Last)	**Birth Date**	**Age**	**Social Security #**	**Sex:** ☐ **M** ☐ **F**

Address		
City	State	Zip
Email Address (We will never rent or sell your email address – we value your privacy.)		
Home Phone Okay to leave voice message? ☐ Yes ☐ No		
Cell Phone Okay to leave voice message? ☐ Yes ☐ No		
Responsible Party or Parent's Name (if minor)	Guarantor Birth Date	
Employer or Parent Occupation	Work Phone	

Marital Status: ☐ S ☐ M ☐ D ☐ W

SPOUSE'S INFORMATION

Spouse's Name
Spouse's Employer
Spouse's Work Phone
Spouse's Cell Phone
Spouse's Email

RACE ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White

ETHNICITY ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Preferred Language

Insurance | Please present your insurance card to the receptionist.

PRIMARY INSURANCE CARRIER			**SECONDARY INSURANCE CARRIER**		
Insurance Company Name			Insurance Company Name		
Address			Address		
City	State	Zip	City	State	Zip
Phone	Policy Number		Phone	Policy Number	
Group Number / Name			Group Number / Name		
Insured Name & DOB			Insured Name & DOB		
Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Dependent			Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Dependent		

Emergency Contact

Name	Relationship	Home Phone		Cell Phone
Address	City	State	Zip	Email

Preferred Pharmacy

Pharmacy Name	Pharmacy Location

Workers' Compensation

Not Applicable ☐

IS THIS A WORKERS' COMPENSATION CLAIM? ☐ Yes ☐ No

Workers' Compensation Billing Address

Accident/Injury Information (if applicable)

Not Applicable ☐

Where did the injury occur? (example: park) _____

Were you struck by an object? ☐ Yes ☐ No If Yes, what type of object? _____

Where did you fall? (example: kitchen, bathroom, garage) _____

Where did you fall from? (example: ladder, roof, steps) _____

If you were in a motor vehicle accident, were you the driver or passenger? _____

Authorization for Release of Information

Can we leave results to internal and external office testing or referrals in email or voicemail? ☐ Yes ☐ No

Whom can receive information on your behalf regarding testing or referrals? Name: _____

Patient Consent for Treatment

1. I voluntarily consent to any and all health care treatment and diagnostic procedures provided by Doctors Care and its associated physicians, clinicians and other personnel. I am aware that the practice of medicine and other health care 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 the treatments or examinations at Doctors Care.
2. I consent to the use and disclosure of my/the patient's protected health information for purposes of obtaining payment for services rendered to me/the patient, treatment and health care operations consistent with the Doctors Care Notice of Privacy Practices.
3. I authorize payment of medical benefits to Doctors Care physicians or their designee for services rendered.
4. I give permission to obtain all my medication/prescription history when using an electronic system to process prescriptions for my medical treatment.

I have received a copy of the Notice of Privacy Practice and Financial Policy Notice. ☐ Yes ☐ No Initial _____

WORKERS' COMPENSATION PATIENTS: I hereby authorize Doctors Care to speak to a rehabilitation specialist, my employer, my insurance carrier or other professionals involved in my care of rehabilitation, regarding my medical records and the treatment I have received or will receive.

_____ _____

Patient or Authorized Person's Signature Date

FOR INTERNAL USE ONLY

DocuTAP Visit ID: _____ Co-Pay Collected: $ _____

Patient Medical History

Today's Date: _____

Patient Name: _____ Date of Birth: _____

Allergies

No Known Allergies ☐

_____ _____

Medicine Other

Current Medications (include non-prescription products)

No Current Medications ☐

1. _____ 3. _____ 5. _____ 7. _____

2. _____ 4. _____ 6. _____ 8. _____

Patient History

PLEASE MAKE AN (X) BY ANY OF THESE CONDITIONS YOU MAY HAVE HAD IN THE PAST:

☐ Heart disease	☐ Kidney, bladder or prostate disease	☐ Stroke	☐ Mental health problems
☐ High blood pressure	☐ Joint replacement	☐ Seizures	☐ Depression
☐ High cholesterol	☐ Liver disease	☐ Nerve impairment	☐ Chronic skin disease
☐ Lung disease	☐ Bowel disease	☐ Cervical spine disorder	☐ Sleep apnea
☐ Diabetes	☐ Cancer (past or present)	☐ Lumbar spine disorder	☐ Other:
☐ Hypoglycemia (low glucose)	☐ Anemia or other blood disease	☐ Severe headaches	_____
☐ Thyroid disease	☐ Blood clots	☐ Tuberculosis/TB	_____
☐ Stomach disease	☐ Bleeding tendency	☐ Muscle disease	_____

PAST MEDICAL CONDITIONS:

_____ _____

Approximate Date Condition Approximate Date Condition

_____ _____

Approximate Date Condition Approximate Date Condition

ORTHOPEDIC OR OTHER MAJOR SURGERIES:

_____ _____

Approximate Date Surgery Approximate Date Surgery

_____ _____

Approximate Date Surgery Approximate Date Surgery

Family History

Mother:	☐ Hypertension	☐ Diabetes	☐ Cancer	☐ Other (please specify) _____	☐ N/A
Father:	☐ Hypertension	☐ Diabetes	☐ Cancer	☐ Other (please specify) _____	☐ N/A
Brother:	☐ Hypertension	☐ Diabetes	☐ Cancer	☐ Other (please specify) _____	☐ N/A
Sister:	☐ Hypertension	☐ Diabetes	☐ Cancer	☐ Other (please specify) _____	☐ N/A
Grandmother (M):	☐ Hypertension	☐ Diabetes	☐ Cancer	☐ Other (please specify) _____	☐ N/A
Grandmother (P):	☐ Hypertension	☐ Diabetes	☐ Cancer	☐ Other (please specify) _____	☐ N/A
Grandfather (M):	☐ Hypertension	☐ Diabetes	☐ Cancer	☐ Other (please specify) _____	☐ N/A
Grandfather (P):	☐ Hypertension	☐ Diabetes	☐ Cancer	☐ Other (please specify) _____	☐ N/A

Personal Habits

Do you drink alcoholic beverages? ..... ☐ Yes ☐ No If yes, _____ drinks per ☐ Day ☐ Week ☐ Month

Do you smoke or chew tobacco?..... ☐ Yes ☐ No If yes, _____ per day, _____ years of use

Do you use an e-cigarette?..... ☐ Yes ☐ No If yes, _____ per day, _____ years of use

Review of Symptoms

	Do you have		If yes, explain
SKIN	Rashes, bumps, lumps, open sores, or wounds	☐ Yes ☐ No	
HEAD | EYES | EARS NOSE | THROAT	Failing eyesight, falls, seizures, vertigo, blackouts, hoarseness, or nasal congestion	☐ Yes ☐ No	
LUNGS	Unexpected breathlessness, wheezing (day or night), blood in sputum, or chronic cough	☐ Yes ☐ No	
HEART	Chest pain, irregular heartbeat, or pacemaker	☐ Yes ☐ No	
BOWELS	Blood in stool, change in bowel habits, worrisome indigestion, or abdominal pain	☐ Yes ☐ No	
BLADDER | KIDNEY	Trouble urinating, infections, or blood in urine	☐ Yes ☐ No	
EMOTIONAL	Any mental health problems, depression, or suicidal tendency	☐ Yes ☐ No	
MUSCULOSKELETAL	Arthritis, fractures, injuries, muscle weakness, or cramping	☐ Yes ☐ No	

Notice of Privacy Practices: Doctors Care, PA

This notice describes how medical information about you may be used, disclosed, and how you can get access to this information. Please review this document carefully.

Patient Health Information (PHI)
Under federal law, your patient health information (PHI) is protected and confidential. Patient health information (PHI) includes information about your symptoms, test results, diagnosis, treatment, and related medical information. Your patient health information (PHI) also includes payment, billing and insurance information. We are committed to protect the privacy of your PHI.

How we use your patient health information (PHI)
This Notice of Privacy Practices (Notice) describes how we may use within our practice or network and disclose (share outside of our practice or network) your PHI to carry out treatment, payment or health care operations, for administrative purposes, for evaluation of the quality of care, and so forth. We may also share your PHI for other purposes that are permitted or required by law. This Notice also describes your rights to access and control your PHI. Under some circumstances we may be required to use or disclose your PHI without your consent.

Treatment: We will use and disclose your PHI to provide you with medical treatment or services. We may also disclose your PHI 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 PHI 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 and maintain records of payments from your health plan. PHI may be shared with the following: billing companies, insurance companies (health plans), government agencies in order to assist with qualifications of benefits, or collection agencies.

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 and request that our patients maintain strict confidentiality of PHI.

We may use and disclose your PHI to perform various routine functions (e.g. quality evaluations or records analysis, training students, other health care providers or ancillary staff such as billing personnel, to assist in resolving problems or complaints within the practice). We may use your PHI to 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 PHI with Business Associates who assist us in performing routine operational functions, but we will always obtain assurances from them to protect your PHI the same as we do.

Special Situations that DO NOT require your permission: 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. Your PHI may also be shared if you are an inmate or under custody of the law which is necessary for your health or the health and safety of other individuals.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose PHI of individuals who are Armed Forces personnel for activities deemed necessary by appropriate military command authorities, for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or to foreign military authority if you are a member of that foreign military services.

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 PHI, for example:

Unless you object, we may share your PHI with friends or family members, or other persons directly identified by you at the level they are involved in your care or payment of services. If you are not present or able to agree/object, the healthcare provider using professional judgment will determine if it is in your best interest to share the information. We may use or disclose PHI to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. We may use or disclose your PHI to an authorized public or private entity to assist in disaster relief efforts.

You may request restrictions on certain uses and disclosures of your PHI. 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 PHI. 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 by submitting a written request. You may request a list of instances where we have disclosed PHI 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.

You have the right to obtain a paper copy of this Notice from us, upon request. We will provide you a copy of this Notice on the first day we treat you at our facility. In an emergency situation we will give you this Notice as soon as possible. You have the right to receive notification of any breach of your protected health information.

Our Legal Duty
We are required by law to protect and maintain the privacy of your PHI, to provide this Notice about our legal duties and privacy practices regarding PHI, 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 and on our website at www.DoctorsCare.com. 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 Privacy Officer listed below. You may also 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: Privacy Officer
1818 Henderson Street
Columbia, SC 29201

Email: privacyofficer@doctorscare.com

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

EFFECTIVE APRIL 2013

Financial Policy and Disclosure

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 Doctors Care and UCI Medical Affiliates.

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. Non-covered services and supplies may include medical supplies, durable medical equipment, medications, x-ray supplies, and labs you receive at any Doctors Care facility.
- If we have not received a payment from your insurance company within the contracted time frame specified by your insurance company's contract with Doctors Care, 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 workers' compensation carrier for services rendered.
- If you are covered under workers' compensation, we will accept the payments by the workers' compensation carrier as per contracted rates based on the mandated SC state fee schedule.
- If payment is denied from your workers' compensation carrier, a claim will be submitted with your private insurance on file. Should the private insurance deny the claim, you will become responsible for the entire balance of your services.
- 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.

Overdue and Credit Balances
- All over-due patient balances will be sent to collections.
- All accounts sent to collections will be charged a $25 collection fee in addition to the account balance.
- Credit balances under $15 aged over 60 days may be written off.

Divorce or Custody Case Policy
- The parent or guardian who brings the patient into our office will be held financially responsible, regardless of the provisions in the divorce decree, or who has custody, or who has the insurance.

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, copay, 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.

Your cooperation is greatly appreciated.